

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be accepted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
14812

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14820

|   |  |   |        |   |  |  |                            |  |  |
|---|--|---|--------|---|--|--|----------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  | First   | Middle | Last  | 2a. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>8</u> Year <u>1968</u> |  | 2b. HOUR<br><u>10 P.M.</u> |  |  |
| 3. SEX<br><u>Female</u>   |  | 4. RACE<br><u>Caucasian</u>   |        | 5. DATE OF BIRTH<br><u>6-5-08</u>   |  | 6. AGE (In years<br>lost birthday)<br><u>60</u> YRS.                                 |                            | IF UNDER 1 YEAR<br>MONTHS <u>  </u> DAYS <u>  </u> | IF UNDER 24 HRS.<br>HOURS <u>  </u> MIN. <u>  </u> |
| 7a. BIRTHPLACE (State or foreign<br>country) <u>Michigan</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><u>Prince George's</u> Md.                                     |                            |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Cheverly</u>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><u>Prince Geo.Gen'l Hospital</u> |        | 12a. USUAL OCCUPATION (Kind of work done<br>during preceding week or months, even if retired.)<br><u>Housewife</u>  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY <u>Home</u>                                     |                            |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <u>Maryland</u>  |  | 13b. CITY<br><u>Prince George's</u>   |        | 13c. CITY OR TOWN<br><u>Suitland</u>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                            | 13e. STREET AND NUMBER<br><u>4830 Homer Ave.</u>   |  |
| 14. FATHER'S NAME<br>First <u>William</u> Middle <u>  </u> Last <u>Page</u>   |  | 15. MOTHER'S MAIDEN NAME First <u>Cora</u> Middle <u>(Unknown)</u> Last <u>  </u>                                   |        |   |  |  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no or unknown <u>no</u> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><u>Unknown</u>  |        | 17. INFORMANT Address<br><u>Arthur W. Anderson, same as #13 (Husband)</u>   |  |  |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4270 Left lower lobe bronchopneumonia.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>  </u> |  |   |        |   |  |  |                            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>4341 Surgical absence of right lung and right breast.</u>   |  |   |        |   |  |  |                            |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? <u>Yes</u>   |                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>19</u><br>P.M. <u>  </u>           |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |                            |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                     |        | 21f. LOCATION Street or R.F.D. No. <u>  </u> City or Town <u>  </u> County <u>  </u> State <u>  </u>  |  |  |                            |  |  |
| 22a. I certify that (I) <del>(this hospital)</del> attended the deceased from <u>Sept. 1950</u> , to <u>Oct. 8, 1968</u> , that (I) <del>last</del> saw the deceased alive on <u>Oct. 8, 1968</u> , and that in (my) <del>(my)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <del>(did not)</del> view the body after death.                  |  |   |        |   |  |  |                            |  |  |
| 22b. SIGNATURE<br><u>William Brainin</u> DEGREE <u>  </u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |   |        |   |  | 22c. DATE SIGNED<br><u>Oct. 9, 1968</u>  |                            |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>William Brainin, M. D.</u>   |  |   |        | 22e. ADDRESS<br><u>6056 Central Ave., Capital Hgts. Md. 20027</u>   |  |  |                            |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE<br><u>10-12-68</u>  |        | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Suitland, Maryland</u>           |                            |  |  |
| 24. FUNERAL DIRECTOR <u>Wilhelm Funeral Home</u> ADDRESS<br><u>4308 Suitland Rd. SE, Washington, D.C.</u>   |  |   |        | 25a. REC'D BY REGISTRAR<br>DATE <u>OCT 14 1968</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                   |                            |  |  |

01234

• *Self-Insured Retention (SIR)* is the amount of loss that the insured must pay out of pocket before the insurer pays.

of diagnostic report for the

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

MDARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14813

14821

|   |  |   |  |
|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>GEORGE</b> First <b>W</b> Middle <b>ATTICK</b> Last  |  | 2a. DATE OF DEATH<br>Month <b>Oct</b> Day <b>21</b> Year <b>1968</b> 2b. HOUR <b>1:00</b> PM  |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>white</b>  | 5. DATE OF BIRTH<br><b>9/17/15</b>  | 6. AGE (In years<br>last birthday)<br><b>53</b> YRS.   |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Md</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.   |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>Pro Georges Hospt</b> | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Accountant</b>   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>U S Government</b>                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Md</b>  | 13b. COUNTY <b>Pro Geo.</b>  | 13c. CITY OR TOWN <b>College Ht</b>   | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 14. FATHER'S NAME First <b>Charles M</b> Middle <b>Attick</b> Last  | 15. MOTHER'S MAIDEN NAME First <b>Lillian L</b> Middle <b>Bursey</b> Last                                |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)  | 16b. SOCIAL SECURITY NO.<br><b>216 44 7728</b>   | 17. INFORMANT <b>Helen T Attick</b> Address <b>College Heights Estates, Md</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Failure</b><br><b>398X</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Rheumatic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL "BETWEEN ONSET AND DEATH"<br><b>25yr +</b> |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>410X</b>   |  |   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1950</b> , 19____, to <b>1968</b> , 19____, that (I) ( <del>was</del> ) lost<br>saw the deceased alive on <b>Aug 16 68</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the<br>causes stated above, (I) ( <del>we</del> ) (did) ( <del>do</del> ) view the body after death.  |  |   |  |
| 22b. SIGNATURE<br><b>U. L. ETIENNE</b>  | DEGREE <b>M.D.</b>   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             | 22c. DATE SIGNED<br><b>10/4/68</b>   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>U. L. ETIENNE</b>  | 22e. ADDRESS<br><b>College Park, Md</b>  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>10/24/68</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Colmar Manor Pro Geo Md</b>              |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 25 1968</b>  |  |
| ADDRESS<br><b>Hyattsville, Md.</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12841

12841

ATTN: Mr. J. H. ...

George

Point Hypocentral failure  
Rheumatic hand failure  
24yr +

1958

1970

AGE

W. C. ETIENNE  
10/1/07

College Park Md

1958



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14814

14822

|   |  |  |   |   |   |   |  |  |  |
|---|--|--|---|---|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>GERTRUDE</b> First <b>HELEN</b> Middle <b>BAILEY</b> Last  |  |  | 2a. DATE OF DEATH<br>Month <b>10</b> Day <b>4</b> Year <b>68</b>    |   |   | 2b. HOUR<br><b>8:55</b> P.M.  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>3-27-94</b>  |   | 6. AGE (In years last birthday)<br><b>74</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Penna.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Prince Georges</b> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Riverdale</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Leland Memorial Hosp.</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>housekeeper</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DOMESTIC</b>             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Pennsylvania</b>  |  | 13b. COUNTY<br><b>ELK</b>  |   | 13c. CITY OR TOWN<br><b>Kersey</b>  |   | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |
| 14. FATHER'S NAME First <b>TERRANCE</b> Middle <b>BROWN</b> Last  |  |  | 15. MOTHER'S MAIDEN NAME First <b>ROSE</b> Middle <b>ADAMS</b> Last |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or (unknown)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>188-22-9666</b>   |   | 17. INFORMANT<br><b>MRS W.M. BROWN</b> Address <b>1820 BUENA VISTA DRIVE</b><br><b>EGGLID, OHIO</b>   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Infarctus Myocardii</b><br><b>4120</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Arteriosclerosis Myocardii</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c)          |  |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>443X</b>  |  |  |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 2</b> , 19 <b>68</b> , to <b>July 4</b> , 19 <b>68</b> , that (I) <b>(we)</b> lost saw the deceased alive on <b>July 4</b> , 19 <b>68</b> , and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(we)</b> <b>(did)</b> <b>(did not)</b> view the body after death. |  |  |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Robert C. Wingfield</b>  |  |  |   | DEGREE ATTENDING PHYS.<br><input checked="" type="checkbox"/>   |   | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                   |  | 22c. DATE SIGNED<br><b>July 5, 1968</b>                          |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>ROBERT C. WINGFIELD</b>  |  |  |   | 22e. ADDRESS  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-8-68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St Boniface Cem</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Kersey Elk Penn.</b>                                      |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>De Witt Donaldson</b>  |  |  |   | ADDRESS<br><b>Laurel Md</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 8 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>               |  |

1942

RECEIVED

1942

TO THE DIRECTOR, BUREAU OF REVENUE

FROM THE CHIEF, BUREAU OF REVENUE

SUBJECT: [Illegible]

REFERENCE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14815

14823

|  |  |  |              |   |   |  |                     |   |  |
|--|--|--|--------------|---|---|--|---------------------|---|--|
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br>ALVA  | Middle<br>E. | Last<br>BARNES, SR.   | 2a. DATE OF DEATH<br>Month Day Year<br>OCT 4 1968 |  | 2b. HOUR<br>9 P. M. |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |              | 5. DATE OF BIRTH<br>JAN. 3, 1905  |   | 6. AGE (In years<br>last birthday)<br>63 YRS.  |                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>PRINCE GEORGES Md.   |                     |   |  |
| 10. CITY OR TOWN OF DEATH<br>W. HYATTSVILLE  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>6632 24th AVE |              | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>AUTO MECHANIC   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>SAME   |                     |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE MD  |  | 13b. COUNTY PR. GEO  |              | 13c. CITY OR TOWN<br>W. HYATTS.   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                     | 13e. STREET AND NUMBER<br>6632 24th AVE                         |  |
| 14. FATHER'S NAME First Middle Last<br>Barnes  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>That Knowen  |              |   |   |  |                     |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no (or unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.   |              | 17. INFORMANT<br>Mrs. Ada R. Barnes Address 6632 24th AVE W. Hyatts   |   |  |                     |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1890 Hypertrophied right kidney with<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) metastases to lungs & brain<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) 6 Months<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. |  |  |              |   |   |  |                     |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>180X  |  |  |              |   |   |  |                     |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?              |                     |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                       |              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |                     |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                  |              | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |                     |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from May 1968, to Oct 4, 1968, that (I) (we) last<br>saw the deceased alive on Oct 4, 1968, and that (I) (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |              |   |   |  |                     |   |  |
| 22b. SIGNATURE<br>Ermo P. Ingel MD   |  | 22c. DATE SIGNED<br>Oct 4, 1968  |              | 22d. PHYSICIAN'S<br>NAME (Type) ERMO P. INGEL   |   |  |                     |   |  |
| 22e. ADDRESS<br>1905 Queens Chapel Rd Wash DC 20018  |  |  |              |   |   |  |                     |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE<br>Oct. 7, 1968  |              | 23c. NAME OF CEMETERY OR CREMATORY<br>Geo. Washington Cemetery  |   | 23d. LOCATION (City or Town) (County) (State)<br>Adelphi An. Co. Md                  |                     |   |  |
| 24. FUNERAL DIRECTOR<br>J. H. Hattery  |  | 24a. ADDRESS<br>257 Carroll St NW Wash DC  |              | 24b. REC'D BY REGISTRAR<br>DATE OCT 8 1968  |   | 24c. REGISTRAR'S SIGNATURE<br>J. Charles Judge                                       |                     |   |  |



1

RECEIVED  
JAN 10 1981  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 14816  |  |  |  |  |   |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |  |  | 14824  |  |  |  |  |                           |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---------------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print)   |  |  |  |  |   |  |  |  |  | 2a. DATE OF DEATH   |  |  |  |  |   |  |  |  |  | 2b. HOUR   |  |  |  |  |                           |  |  |  |  |
| First Middle Last<br><b>Arthur H Baxter</b>  |  |  |  |  |   |  |  |  |  | Oct. Month 29, Day 1968 <sup>Year</sup>   |  |  |  |  |   |  |  |  |  | 9:05A M  |  |  |  |  |                           |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  |  |  |  | 4. RACE<br><b>Caucasian</b>   |  |  |  |  | 5. DATE OF BIRTH<br><b>Dec 16, 1916</b>   |  |  |  |  | 6. AGE (In years lost birthday)<br><b>51</b> YRS.                               |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS                        |  |  |  |  | IF UNDER 24 HRS HOURS MIN |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md</b>   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.                                |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince Geo. Gen'l Hospital</b> |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Guard</b>   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>P E P co</b>                            |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  |  |  |  | 13b. CITY OR TOWN<br><b>Prince George's Hyattsville</b>   |  |  |  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | 13e. STREET AND NUMBER<br><b>7522-A Hawthorne St.</b>                           |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>George P Baxter</b>  |  |  |  |  |   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Sadie Robinson</b>   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>W W 11</b>  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>218 05 6778</b>  |  |  |  |  | 17. INFORMANT Address<br><b>Nell G Baxter Kentland, Md.</b>   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1579 Terminal Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF -<br>(b) <b>Carcinoma of pancreas</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Melanin to liver &amp; duodenum</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>1579</b> |  |  |  |  |   |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Jan. 1968</b>                |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?            |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |
| 22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>Jan. 1968</b> to <b>Oct. 29, 1968</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Oct. 29, 1968</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |
| 22b. SIGNATURE<br><b>Ohannes Sahakyan, M. D.</b>   |  |  |  |  |   |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  |  |  |  | 22c. DATE SIGNED<br><b>Oct. 30, 1968</b>  |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Ohannes Sahakyan, M. D.</b>   |  |  |  |  |   |  |  |  |  | 22e. ADDRESS<br><b>6001 Landover Rd., Cheverly, Md.</b>   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  |  |  | 23b. DATE<br><b>Nov 1, 1968</b>   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln Cemetery</b>  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Colmar Manor Pro Geo Md</b> |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b>   |  |  |  |  |   |  |  |  |  | ADDRESS<br><b>Hyattsville, Md.</b>  |  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>NOV 4 1968</b>                                    |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |  |  |  |                           |  |  |  |  |

14824

STATEMENT OF DEATH

14818

Arthur, 29, 1983, 10:00

Uncle

Uncle

Uncle, 29, 1983, 10:00

Uncle

Uncle, 29, 1983, 10:00

Uncle

Uncle, 29, 1983, 10:00

Uncle

Uncle, 29, 1983, 10:00

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Uncle, 29, 1983, 10:00

Uncle

Uncle, 29, 1983, 10:00

Uncle



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD. STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14817

CERTIFICATE OF DEATH

14825

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Earl Milton Bean</b>  |  |  | 2a. DATE OF DEATH<br>Oct. Month <b>23</b> , Day <b>1968</b> Year |   |  | 2b. HOUR <b>3:55</b> P M  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br><b>Sept. 17, 1904</b>   |  | 6. AGE (In years lost birthday)<br><b>64</b> YRS.                                 |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Md</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.                                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince Geo.Gen'l Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired Baker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bakery</b>                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Prince George's</b>  |  | 13c. CITY OR TOWN<br><b>Riverdale</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>5703 Nicholson St.</b>  |  | 14. FATHER'S NAME First Middle Last<br><b>Spencer Bean</b>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Ethel S Whipp</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>578 09 6878</b>   |  | 17. INFORMANT<br><b>Naomi G. Bean</b> Address<br><b>East Riverdale, Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>3321</b> IMMEDIATE CAUSE (a) <b>Heredity Spino-cerebellar ataxia with coma;</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>right hemiplegia &amp; aphasia.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____ |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>355x</b>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                     |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) <del>did not</del> attended the deceased from <b>Oct 6, 1968</b> , to <b>Oct. 23, 1968</b> , that (I) <del>was</del> last saw the deceased alive on <b>Oct. 23, 1968</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Don B. Cameron</b>  |  |  |  | 22c. DATE SIGNED<br><b>Oct 23, 1968</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Don B. Cameron, M. D.</b>   |  |  |  | 22e. ADDRESS<br><b>3503 Perry St., Mt. Rainier, Md. 20822</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>Oct 26, 1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Colmar Manor Pro Geo Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b> ADDRESS<br><b>Hyattsville, Md.</b>  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 28 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>                             |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>Irene  |  |  | Middle<br>S.  |  |  | Last<br>Bean   |  |  |
| 3. SEX<br>Female  |  |  | 4. RACE<br>White  |  |  | 5. DATE OF BIRTH<br>12-2-83   |  |  | 2a. DATE OF DEATH<br>Month Day Year<br>October 29 1968                                       |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Prince George Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Riverdale  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Eugene Leland Memorial  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  |  | 13b. COUNTY<br>Prince Geo.  |  |  | 13c. CITY OR TOWN<br>Beltsville   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME First Middle Last<br>John Brady   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Sarah Jones   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>none   |  |  |
| 17. INFORMANT Address<br>Medical Records  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>GASTROINTESTINAL BLEEDING</u><br>571.9 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Esophageal Ulcer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Carcinosis liver</u> |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 days<br>7 yr<br>many yr   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)<br>5810  |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 27</u> , 19 <u>68</u> to <u>Oct. 29</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct. 29</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>R. F. Wilkinson</i>  |  |  | 22c. DATE SIGNED<br>Oct 29.1968   |  |  | 22d. PHYSICIAN'S NAME (Type)<br>R. F. Wilkinson, M.D.   |  |  | 22e. ADDRESS<br>4408 Queensbury Rd., Riverdale, Md.  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  | 23b. DATE<br>11.1.68  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Epiphany Cemetery   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Forestville Maryland                        |  |  |
| 24. FUNERAL DIRECTOR<br>Lee Funeral Home 300.4th st N E Wash. D.C.  |  |  | 25a. REC'D BY REGISTRAR<br>DATE NOV 4 1968  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |  |  |  |  |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |   |  |   |   |                  |  |
|--|--|--|--|--|---|---|--|---|---|------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |   |  |   |   |                  |  |
| 14819  |  |  |  |  | 14827   |   |  |   |   |                  |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  |  | 2a. DATE OF DEATH   |   |  | 2b. HOUR  |   |                  |  |
| First Maude Middle L. Last Bender  |  |  |  |  | Month Oct. Day 28, Year 1968  |   |  | P 12:15 M   |   |                  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   |   | 6. AGE (In years lost birthday)  |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |                  |  |
| Female   |  | Caucasian  |  | March 3, 1901  |   |   | 67 YRS.  |   |   |                  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |   |   |                  |  |
| Ohio   |  | U S A  |  |  |   | Prince George's Md.   |  |   |   |                  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |                  |  |
| Cheverly   |  |  | Prince Geo. Gen'l Hospital   |  |   | Housewife   |  |   |   |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before date of death)  |  |  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 13e. STREET AND NUMBER  |   |                  |  |
| Maryland Prince Geo.   |  |  |  | Coral Hills  |   |   |  | 5313 P Street, SE.  |   |                  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  | 17. INFORMANT   |   |  |   |   |                  |  |
| First Payne Middle Stone Last  |  |  | First Evalina Richardson Middle Last   |  | Address College Park, Md.   |   |  |   |   |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |  | Raymond C. Bender 9711 52nd Ave.  |   |  |   |   |                  |  |
| No   |  |  |  |  |   |   |  |   |   |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |                  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |   |   |  |   |   |                  |  |
| IMMEDIATE CAUSE (a) 4339 Massive acute left cerebral infarct.  |  |  |  |  |   |   |  |   |   |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |  |  |   |   |  |   |   |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |   |   |  |   |   |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |   |   |  |   |   |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |   |   |  |   |   |                  |  |
| 332x   |  |  |  |  |   |   |  |   |   |                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |   |   |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |   |   |                  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |   |   |                  |  |
| 22a. I certify that <del>xx</del> (this hospital) attended the deceased from Oct. 21, 1968, to Oct. 28, 1968, that <del>xx</del> (we) lost saw the deceased alive on Oct. 28, 1968, and that in <del>xx</del> (our) opinion death occurred on the date and hour and from the causes stated above <del>xx</del> (we) (did) (did not) view the body after death. |  |  |  |  |   |   |  |   |   |                  |  |
| 22b. SIGNATURE   |  |  |  |  | DEGREE  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED |  |
| Tomas J. Hernandez, M. D.  |  |  |  |  |   |   |  |   |   | Oct. 28, 1968    |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  | 22e. ADDRESS  |   |  |   |   |                  |  |
|  |  |  |  |  | Prince Geo. Gen'l Hospital, Cheverly, Md.   |   |  |   |   |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |  |   |   |                  |  |
| Burial   |  | 11-1-68  |  | Cedar Hill Cemetery  |   | Suitland, Pr. Geo. Md.  |  |   |   |                  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |   |   |                  |  |
| Wilhelm Funeral Home 4308 Suitland Rd. S. E.   |  |  |  |  | DATE NOV 4 1968   |   | J Charles Judge  |   |   |                  |  |

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Journal of Management Education 33(1)

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CERTIFICATE OF DEATH

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|  |  |                              |  |   |  |   |  |  |  |   |  |   |  |
|--|--|------------------------------|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)  |  | First                        |  | Middle  |  | Last  |  | 2a. DATE OF DEATH  |  |   |  | 2b. HOUR  |  |
| Suzanne  |  |                              |  |   |  | Bennett   |  | Month  |  | Day   |  | Year  |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH  |  |   |  | 6. AGE (In years<br>lost birthday)   |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.                                |  |
| Female   |  | Cav.                         |  | 7-30-1880   |  |   |  | 88 YRS.  |  | MONTHS  |  | DAYS  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |  |   |  |   |  |
| Penna.   |  | U.S.                         |  |   |  | Prince George Md.   |  |  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  |                              |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)   |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)         |  |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY            |  |
| Greenbelt  |  |                              |  | Greenbelt Convalescent Center   |  |   |  | Housewife  |  |   |  | at Home   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  |                              |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  | 13e. STREET AND NUMBER  |  |   |  |
| Md   |  |                              |  | Pr. Geo   |  | Hyattsville   |  | YES  |  | 3911 Commander Drive  |  |   |  |
| 14. FATHER'S NAME  |  |                              |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |  |  |   |  |   |  |
| First Middle Last  |  |                              |  | First Middle Last   |  |   |  |  |  |   |  |   |  |
| Samuel   |  |                              |  | Hallman   |  |   |  | Loring Long  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)  |  |                              |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  |  |  |   |  |   |  |
| No   |  |                              |  |   |  | Mrs. Paul B. Friend 3911-Commander<br>Dr. College Heights |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>437.9<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) <u>Fracture of R hip</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Cerebral arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |                              |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 334x   |  |                              |  |   |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br>FOR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |                              |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>5:30 P.M. Aug 11 1968  |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Fell out of bed |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |                              |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)<br>Greenbelt Convalescent  |  |   |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State<br>7010 Greenbelt Greenbelt PG Md  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11 Aug, 1968, to 5 Oct, 1968, that (I) (we) last<br>saw the deceased alive on 3 Oct 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. Accident  |  |                              |  |   |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Arthur Kaufman MD  |  |                              |  | 22c. DATE SIGNED<br>5 Oct 68  |  |   |  |  |  |   |  |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  |                              |  | 22e. ADDRESS  |  |   |  |  |  |   |  |   |  |
| ARTHUR KAUFMAN   |  |                              |  |   |  |   |  |  |  |   |  |   |  |
| 23a. BURIAL-CREATION,<br>REMOVAL (Specify)   |  |                              |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                        |  | 23d. LOCATION (City or Town) (County) (State)  |  |   |  |   |  |
| Burial   |  |                              |  | Oct 8-1968  |  | East Lawn Memorial  |  | Greenbelt Md   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR   |  |                              |  | ADDRESS   |  |   |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| J. Arthur Walters  |  |                              |  | 1500 Capital St. N.W.<br>Washington D.C.  |  |   |  | DATE OCT 8 1968  |  | Charles Judge   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1988

UNITED STATES OF AMERICA

202



INSTITUTION OF TECHNOLOGY AND ARTS

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14821

CERTIFICATE OF DEATH

14829

|   |  |  |   |   |  |   |  |
|---|--|--|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Arthur E Bingler</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>18</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>10:30</b> <sup>A</sup>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH<br><b>4/12/08</b>  |  | 6. AGE (In years<br>lost birthday)<br><b>60</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>Prince George's General</b> |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) <b>Bus Driver</b>  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY <b>Public School</b>                                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Prince Geo.</b>   |   | 13c. CITY OR TOWN <b>Seat Pleasant</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>309 70th St.</b>   |  | 14. FATHER'S NAME<br>First <b>James E.</b> Middle <b>Bingler</b> Last <b>Bingler</b>                           |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Annie K.</b> Middle <b>Hughson</b> Last <b>Hughson</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no or unknown <b>Yes</b> (If yes, give year or dates of service) <b>WWII</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>577-30-6283</b>   |   | 17. INFORMANT<br>Address <b>Anna R. Ridgeway - Same as # 13</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4201</b><br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Renal shutdown &amp; anemia, persistent shock.</b>   |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/18</b> , 19 <b>68</b> , to <b>18 Oct</b> , 19 <b>68</b> , that (II) (we) last saw the deceased alive on <b>17 Oct</b> , 19 <b>68</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>R Deitz</b>  |  |  |   | 22c. DATE SIGNED<br><b>18 Oct. 1968</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>R Deitz</b>   |  |  |   | 22e. ADDRESS<br><b>Pro Geo Plaza, Hyattsville, Md.</b>  |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE<br><b>Oct 21, 1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Colmar Manor Pro Geo Md.</b>                |  |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b>  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 22 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

14830

|   |  |   |   |   |  |   |  |   |   |  |  |   |  |
|---|--|---|---|---|--|---|--|---|---|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Richard</b>  |  | First <b>L.</b>   |   | Middle <b>Bowman</b>  |  | Last  |  | 2a. DATE OF DEATH<br>Month <b>10</b> Day <b>11</b> Year <b>68</b>       |   |  | 2b. HOUR<br><b>1205PM</b>  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br><b>August 13 1876</b>   |  |   |  | 6. AGE (In years<br>lost birthday)<br><b>92</b> YRS.                    |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Ohio</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.  |  |   |   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hyattsville</b>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Carroll Manor</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Mechanic</b> |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>USGovt</b> |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>D.C.</b> <b>Washington</b> <b>1799</b>  |  |   | 13b. CITY OR TOWN<br><b>Washington</b>  |   | 13c. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>4922 1/2 32nd Ave.</b>                      |   |   |  |  |   |  |
| 14. FATHER'S NAME<br>First <b>Richard</b> Middle <b>Bowman</b> Last   |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Ann</b> Middle <b>E.</b> Last <b>Brennan</b>                       |   |  |   |  |   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)<br><b>None</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>579 60 3355</b>  |   | 17. INFORMANT<br>Address <b>Richard Timmons Washington, D.C.</b>                                       |   |  |   |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   |  |   |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>4 years</b> |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4200</b>   |  |   |   |   |  |   |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>               |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/17</b> , 19 <b>67</b> , to <b>10/11</b> , 19 <b>68</b> , that (I) (we) last<br>saw the deceased alive on <b>Oct. 10</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |   |   |   |  |   |  |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Thomas F Collins</b>   |  | DEGREE  |   | ATTENDING<br>PHYS. <input checked="" type="checkbox"/>  |  | MED.<br>DIRECTOR <input type="checkbox"/>   |  | STAFF<br>PHYS. <input type="checkbox"/>                                 |   | 22c. DATE SIGNED<br><b>10/11/68</b>              |  |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>THOMAS F COLLINS</b>  |  | 22e. ADDRESS<br><b>355 - H ST NE</b>  |   |   |  |   |  |   |   |  |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/15/1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glenwood Cemetery</b>  |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington, D.C.</b> |   |   |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Nalley's Funeral Home</b>  |  | ADDRESS<br><b>Mt. Rainier, Md.</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 15 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |   |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF TEXAS

40021





Page 4 may be retained by the hospital or offending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



| <div style="display: flex; justify-content: space-between;"> <span>14823</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>14831</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br/> <b>CERTIFICATE OF DEATH</b> </div>  |  |  |  |   |  |  |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Glen R. Brant</b>   |  |  |  | 2a. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>2</b> Year <b>1968</b>  |  |  |  | 2b. HOUR DOA<br><b>6:15P</b>   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br><b>August 27, 1928</b>  |  | 6. AGE (In years last birthday)<br><b>40</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                                     |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>                                   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |  | DOA <b>DOA</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince Geo.Gen'l Hospital</b>  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>School Teacher</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Jr. High</b>                                 |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Prince George's</b>  |  | 13c. CITY OR TOWN<br><b>Laurel</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  | 13e. STREET AND NUMBER<br><b>13307 Edinburg Lane</b>                                 |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Ralph R. Brant</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Hazel Moreland</b>   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br><b>Yes Korean War</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-22-6038</b>                               |  | 17. INFORMANT Address<br><b>Mrs. Martha Brant, 13307 Edinburg Lane, Laurel, Md</b>  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction.</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.         |  |  |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b> |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>White <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |  | County   |  | State  |  |
| 22a. I certify that (I) <del>did not</del> attended the deceased from <b>Oct. 2, 1968</b> , to <b>Oct. 2, 1968</b> , that <del>we</del> (we) last saw the deceased alive on <b>Oct. 2, 1968</b> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did) <del>did not</del> view the body after death. |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Don B. Cameron</b>   |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  |  |  | 22c. DATE SIGNED<br><b>Oct. 3, 1968</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Don B. Cameron, M. D.</b>  |  |  |  | 22e. ADDRESS<br><b>3503 Perry St., Mt. Rainier, Md. 20822</b>   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>10/ 5/1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Near Cumbe land Alleg Md</b>                                 |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Hafer, Jr.</b>   |  |  |  | ADDRESS<br><b>230 Balto Ave. Cumberland</b>   |  | 25a. REC'D BY REGISTRAR<br><b>OCT 7 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                   |  |  |  |

2932

James H. Campbell, Director

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# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## Item 8 Film 06 11/7/68 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14824 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14832

|  |  |                         |   |                                    |  |   |  |   |  |   |  |   |  |  |
|--|--|-------------------------|---|------------------------------------|--|---|--|---|--|---|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print)<br><b>Ethel</b>  |  |                         | First Middle Last<br><b>Braxton</b>   |                                    |  | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br><b>10-28-68</b>  |  |   | 2b. HOUR<br>1:25am   |   |  |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Negro</b> |   | 5. DATE OF BIRTH<br><b>3-11-37</b> |  | 6. AGE (In years last birthday)<br><b>31</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>10-28-68</b> |  | 2d. HOUR<br>1:25am  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>D. C.</b>  |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           |  |   | 9. COUNTY OF DEATH<br><b>Prince George's</b>   |   |  | Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince George Hospital</b>                                 |                                    |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br><b>District of Columbia</b>   |  |                         | 13b. COUNTY<br><b>Washington</b>  |                                    |  | 13c. CITY OR TOWN<br><b>Washington</b>  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  | 13e. STREET AND NUMBER<br><b>2313 Douglas Street N.E.</b> |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>William Tolliver</b>  |  |                         | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Geneva Smith</b>  |                                    |  |   |  |   |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |  |                         | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>None</b>  |                                    |  | 17. INFORMANT   |  |   | ADDRESS  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>814.7</b><br>IMMEDIATE CAUSE (a) <b>Laceration of brain</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Trauma - struck by car</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                      |  |                         |   |                                    |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>8124</b>   |  |                         |   |                                    |  |   |  |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                                    |  |   |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |   |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br><b>11:44pm 10-12-19 68</b>   |                                    |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Pedestrian struck by car</b>  |  |   |  |   |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>U.S. Rt. 1 at Muirkirk Road, Prince George County, Md.</b> |                                    |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |                         |   |                                    |  |   |  |   |  |   |  |   |  |  |
| ACTUAL SIGNATURE<br><b>John Kenne MD</b>   |  |                         | EXAMINER'S NAME (Type)<br><b>John Kenne MD</b>  |                                    |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |   | 22b. DATE SIGNED<br><b>10-28-68</b>  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                         | 23b. DATE<br><b>10-1-68</b>   |                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Queens Chapel Methodist Ch. Cemetery</b>   |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Muirkirk, Maryland</b>           |   |  |   |  |  |
| 24. FUNERAL HOME<br><b>John T. Rhines Company Funeral Home</b><br><b>3015 12th Street, N. E.</b>   |  |                         |   |                                    |  | 25a. REC'D BY REGISTRAR<br><b>NOV 1 1968</b>  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>                                |   |  |   |  |  |

14833

14833

MEDICAL EXAMINER'S CERTIFICATE OF FINDINGS

|                               |  |                          |  |                               |  |
|-------------------------------|--|--------------------------|--|-------------------------------|--|
| Name of Deceased              |  | Date of Death            |  | Place of Death                |  |
| John Doe                      |  | 11-11-58                 |  | New York, N.Y.                |  |
| Age                           |  | Sex                      |  | Race                          |  |
| 45                            |  | Male                     |  | Caucasian                     |  |
| Occupation                    |  | Cause of Death           |  | Manner of Death               |  |
| Police Officer                |  | Heart Disease            |  | Natural                       |  |
| Signature of Examiner         |  | Signature of Coroner     |  | Signature of Medical Examiner |  |
| [Signature]                   |  | [Signature]              |  | [Signature]                   |  |
| Date of Examination           |  | Time of Examination      |  | Location of Examination       |  |
| 11-11-58                      |  | 10:00 AM                 |  | New York, N.Y.                |  |
| Findings                      |  | Remarks                  |  | Disposition                   |  |
| No significant findings.      |  | No significant findings. |  | No significant findings.      |  |
| Signature of Medical Examiner |  | Signature of Coroner     |  | Signature of Medical Examiner |  |
| [Signature]                   |  | [Signature]              |  | [Signature]                   |  |
| Date of Examination           |  | Time of Examination      |  | Location of Examination       |  |
| 11-11-58                      |  | 10:00 AM                 |  | New York, N.Y.                |  |

NOV 1 1958

3015 10th Street N.E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 7-68

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                              |  |  |                                    |   |   |   |                                   |  |                  |  |
|---|--|------------------------------|--|--|------------------------------------|---|---|---|-----------------------------------|--|------------------|--|
| 14825   |  |                              |  |  | 14833                              |   |   |   |                                   |  |                  |  |
| 1. DECEASED-NAME (Type or print)  |  |                              |  |  | 2a. DATE OF DEATH                  |   |   |   |                                   | 2b. HOUR                                     |                  |  |
| First Middle Last   |  |                              |  |  | Month Day Year                     |   |   |   |                                   | A  |                  |  |
| Baby Boy Bristol  |  |                              |  |  | Oct. 24, 1968                      |   |   |   |                                   | 10:45M                                       |                  |  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH   |                                    |   | 6. AGE (In years lost birthday)               |   | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS. |  |
| Male  |  | Caucasian                    |  | Oct. 22, 1968  |                                    |   | YRS.  |   | MONTHS DAYS                       |  | HOURS MIN        |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    |   | 9. COUNTY OF DEATH                            |   |                                   |  |                  |  |
| Maryland  |  | U.S.A.                       |  |  |                                    |   | Prince George's Md.                           |   |                                   |  |                  |  |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |                  |  |
| Cheverly  |  |                              | Prince Geo. Gen'l Hospital   |  |                                    |   |   |   |                                   |  |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |                              | 13b. COUNTY  |  |                                    | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |                  |  |
| Maryland  |  |                              | Prince George's  |  |                                    | Landover  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |                                   | 7210 Forest Rd., #2                          |                  |  |
| 14. FATHER'S NAME   |  |                              | 15. MOTHER'S MAIDEN NAME   |  |                                    |   |   |   |                                   |  |                  |  |
| First Middle Last   |  |                              | First Middle Last  |  |                                    |   |   |   |                                   |  |                  |  |
| William Earl Bristol  |  |                              | Barbara Nell Collins   |  |                                    |   |   |   |                                   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  |                              | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT Address   |   |   |                                   |  |                  |  |
|   |  |                              |  |  |                                    |   |   |   |                                   |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                              |  |  |                                    |   |   |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |  |
| PART I. DEATH WAS CAUSED BY:  |  |                              |  |  |                                    |   |   |   |                                   |  |                  |  |
| IMMEDIATE CAUSE (a) Fracture of skull with subdural & epidural hemorrhage   |  |                              |  |  |                                    |   |   |   |                                   |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Tontorial tear bilateral with hemorrhage in posterior fossa.   |  |                              |  |  |                                    |   |   |   |                                   |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |                              |  |  |                                    |   |   |   |                                   |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |                              |  |  |                                    |   |   |   |                                   |  |                  |  |
| 7600  |  |                              |  |  |                                    |   |   |   |                                   |  |                  |  |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes          |                                   |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |   |   |                                   |  |                  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |   |   |                                   |  |                  |  |
| 22a. I certify that (I) <del>did not</del> attended the deceased from Oct. 22, 1968, to Oct. 24, 1968, that (I) <del>was</del> last saw the deceased alive on Oct. 24, 1968, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death. |  |                              |  |  |                                    |   |   |   |                                   |  |                  |  |
| 22b. SIGNATURE  |  |                              | 22c. DATE SIGNED   |  |                                    |   |   |   |                                   |  |                  |  |
| Bernardo Alvarado, M. D.  |  |                              | Oct. 24, 1968  |  |                                    |   |   |   |                                   |  |                  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |                              | 22e. ADDRESS   |  |                                    |   |   |   |                                   |  |                  |  |
| Bernardo Alvarado, M. D.  |  |                              | 6201 Riverdale Rd., Riverdale, Md. 20840                                     |  |                                    |   |   |   |                                   |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION (City or Town) (County) (State) |   |                                   |  |                  |  |
|   |  |                              | 11-2-68  |  | Prince George's General            |   | Cheverly, Maryland                            |   |                                   |  |                  |  |
| 24. FUNERAL DIRECTOR  |  |                              | ADDRESS  |  |                                    | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE  |                                   |  |                  |  |
| Henry W. Penn, Jr. Administrator  |  |                              | Hospital   |  |                                    | NOV 6 1968  |   | Charles Judge   |                                   |  |                  |  |



0035



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

14826

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14834

|   |   |   |   |   |
|---|---|---|---|---|
| 1. DECEASED-NAME<br>(Type or print) <b>GRACE JANET BROSNIHAN</b>  |   | 2a. DATE OF DEATH<br>Month <b>October</b> Day <b>4</b> Year <b>1968</b>               |   | 2b. HOUR<br><b>7:15 P.M.</b>                                    |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>W.</b>  | 5. DATE OF BIRTH<br><b>Dec. 2, 1921</b>   |   | 6. AGE (In years last birthday)<br><b>46</b> YRS.               |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MASS.</b>   |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. COUNTY OF DEATH<br><b>PRINCE GEORGE</b>  |   | Md.   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>COLLEGE PARK</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>5703 VASSAR DR</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b>   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   | 13b. COUNTY<br><b>PRINCE GEORGE</b>   | 13c. CITY OR TOWN<br><b>COLLEGE PARK</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET AND NUMBER<br><b>5703 VASSAR DR.</b>                |
| 14. FATHER'S NAME<br>First <b>JOSEPH</b> Middle <b>PRUNIER</b> Last <b>PRUNIER</b>  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>ROSE</b> Middle <b>HARPER</b> Last <b>HARPER</b> |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>FRANCIS J. BROSNIHAN - Husband - ABOVE.</b> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b><br><b>1530</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma of appendix</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>2 yrs.</b>                         |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 mo.</b>    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>1530</b>   |   |   |   |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. <b>19</b>                                     | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)       |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                          | 21f. LOCATION Street or R.F.D. No. City or Town County State                          |   |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>9-27, 1968</b> to <b>10-4, 1968</b> , that (1) (we) last saw the deceased alive on <b>10-2, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |   |   |   |   |
| 22b. SIGNATURE<br><b>R.D. Bauer M.D.</b>  |   | DEGREE<br><b>M.D.</b>   | ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          | 22c. DATE SIGNED<br><b>10-4-68</b>                              |
| 22d. PHYSICIAN'S NAME (Type)<br><b>R.D. Bauer M.D.</b>  |   | 22e. ADDRESS<br><b>2513 Buck Lodge Rd. Adelphi Md.</b>                                |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE<br><b>10/7/68</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN</b>                           | 23d. LOCATION (City or Town)<br><b>SILVER SPRINGS, Md.</b>  | (County) <b>P.G.</b> (State)                                    |
| 24. FUNERAL DIRECTOR<br><b>F. GASCH'S SONS - Hyattsville, Md.</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 8 1968</b>                                     | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |   |

22841

ADA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
14827  
14836  
CERTIFICATE OF DEATH

|  |  |  |  |   |  |   |  |  |   |  |
|--|--|--|--|---|--|---|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>George E Brumfield</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>20</b> Year <b>1968</b>  |   |  | 2b. HOUR<br><b>9:30</b> P   |  |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>                    |  | 5. DATE OF BIRTH<br><b>Feb. 2, 1904</b>   |  | 6. AGE (In years last birthday)<br><b>64</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____ |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Penn.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Prince George's Md.</b>  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince Geo. Gen'l Hospital</b>                                  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>School Teacher</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Charles County</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Charles</b>  |   |  | 13c. CITY OR TOWN<br><b>Laplata</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 13e. STREET AND NUMBER<br><b>Woodcrest Apts.,</b>  |  |  | 13f. CITY OR TOWN<br><b>Regency Nursing Home</b>   |   |  | 13g. STREET AND NUMBER<br><b>Regency Nursing Home</b>   |  |  | 13h. CITY OR TOWN<br><b>Regency Nursing Home</b>  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Howard Brumfield</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Laura Rugg</b>  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>206-07-6346A</b>   |  |
| 17. INFORMANT<br><b>Wm. F. Brumfield</b>   |  |  | Address<br><b>Laurel, Md.</b>  |   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma - right - with metastasis</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>to mediastinal lymph node - hilar lymph nodes - lungs and liver.</b><br>(b) <b>lymph nodes - lungs and liver.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Bilateral Broncho-pneumonia.</b> |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>1621</b>       |  |  | 19a. DATE OF OPERATION   |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>  |  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) |   |  | 21b. TIME OF INJURY<br>HOUR A.M. _____ Month _____ Day _____ Year _____<br>P.M. _____   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |   |  | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____  |  |  | 22a. I certify that (I) <del>this hospital</del> attended the deceased from <b>7-5-</b> , 19 <b>68</b> , to <b>Oct. 20</b> , 19 <b>68</b> , that (I) <del>xxx</del> last saw the deceased alive on <b>Oct. 20</b> , 19 <b>68</b> , and that in (my) <del>xxx</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>xxx</del> (did) <del>xxx</del> view the body after death. |  |
| 22b. SIGNATURE<br><b>Oliver B Bond</b>   |  |  | 22c. DATE SIGNED<br><b>10-21-68</b>  |   |  | 22d. PHYSICIAN'S NAME (Type)<br><b>Oliver Bond, M. D.</b>   |  |  | 22e. ADDRESS<br><b>6872 Riverdale Rd., Lanham, Md. 20801</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  |  | 23b. DATE<br><b>Oct. 24, 1968</b>  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Trinity Mem. Gardens</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Waldorf, Charles, Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>AREHART FUNERAL HOME INC</b>  |  |  | ADDRESS<br><b>LAPLATA, MD</b>  |   |  | 25a. REC'D BY REGISTRAR<br><b>OCT 25 1968</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>  |  |

14836

STATE OF TEXAS

1907

George E. Brown, Jr., Dec. 20, 1907

John A. Brown, Dec. 20, 1907

John A. Brown, Dec. 20, 1907

John A. Brown, Dec. 20, 1907

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>14828</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>14837</div>   |  |  |  |   |                    |   |   |   |  |  |                  |  |
|--|--|--|--|---|--------------------|---|---|---|--|--|------------------|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  |   | Middle             |   | Last  |   | 2a. DATE OF DEATH                          |  | 2b. HOUR         |  |
| Lennie   |  |  | Burnley  |   | Oct.               |   | Month 28 Day 1968   |   | Year                                       |  | 4:30 A M         |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |                    |   | 6. AGE (In years lost birthday)   |   | IF UNDER 1 YEAR                            |  | IF UNDER 24 HRS. |  |
| Male   |  | Caucasian  |  | Jan. 18, 1912   |                    |   | 56 YRS.   |   | MONTHS DAYS                                |  | HOURS MIN        |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                    | 9. COUNTY OF DEATH  |   |   |  |  |                  |  |
| Va   |  | U S A  |  |   |                    | Prince George's Md.   |   |   |  |  |                  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |   | 12b. KIND OF BUSINESS OR INDUSTRY          |  |                  |  |
| Cheverly   |  |  | Prince Geo.Gen'l Hospital  |   |                    | Welder  |   |   | steel                                      |  |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER                     |  |                  |  |
| Maryland   |  |  | Prince George's  |   | Riverdale          |   |   |   | 5816 Quintanna Street                      |  |                  |  |
| 14. FATHER'S NAME  |  |  | First  |   | Middle             |   | Last  |   | 15. MOTHER'S MAIDEN NAME First Middle Last |  |                  |  |
| John Burnley   |  |  |  |   |                    |   |   |   | Asby Cash                                  |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT      |   |   | Address   |  |  |                  |  |
|  |  |  | 231 07 6087  |   | Margaret C Burnley |   |   | E Riverdale, Md.  |  |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |                    |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |   |                    |   |   |   |  |  |                  |  |
| IMMEDIATE CAUSE (a) <u>Heart Failure</u>   |  |  |  |   |                    |   |   |   |  | 24 hr  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF <u>Cor Pulmonale</u>  |  |  |  |   |                    |   |   |   |  | w hr   |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |                    |   |   |   |  |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF <u>Metastatic Ca of lung</u>  |  |  |  |   |                    |   |   |   |  | 2 yr   |                  |  |
| (c)  |  |  |  |   |                    |   |   |   |  |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |                    |   |   |   |  |  |                  |  |
| 163x   |  |  |  |   |                    |   |   |   |  |  |                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |                  |  |
|  |  |  |  |   |                    |   |   |   |  |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                    |   |   |   |  |  |                  |  |
|  |  | HOUR A.M. Month Day Year P.M. 19   |  |   |                    |   |   |   |  |  |                  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                    |   |   |   |  |  |                  |  |
|  |  |  |  |   |                    |   |   |   |  |  |                  |  |
| 22a. I certify that (I) <del>did not</del> attended the deceased from Dec. 1965, to Oct. 28, 1968, that (I) <del>did not</del> lost saw the deceased alive on Oct. 28, 1968, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did not</del> (did) view the body after death. |  |  |  |   |                    |   |   |   |  |  |                  |  |
| 22b. SIGNATURE   |  |  |  |   |                    |   |   | DEGREE  |  | 22c. DATE SIGNED                             |                  |  |
| John Kehoe, M. D.  |  |  |  |   |                    |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | Oct. 28, 1968                                |                  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |   |                    |   |   | 22e. ADDRESS  |  |  |                  |  |
| John Kehoe, M. D.  |  |  |  |   |                    |   |   | 6300 Riverdale Rd. Riverdale, Md.   |  |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                    | 23d. LOCATION (City or Town) (County) (State)   |   |   |  |  |                  |  |
| Burial   |  | Oct 31, 1968   |  | Burnley Family Cemetery   |                    | Shipman Nelson Va   |   |   |  |  |                  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |   |                    | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE  |  |  |                  |  |
| F. Gasch's Sons Hyattsville, Md  |  |  |  |   |                    | DATE OCT 31 1968  |   | J Charles Judge   |  |  |                  |  |

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0300 Livermore Rd. Livermore, CA 94550

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 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |  |  |   |   |
|---|--|--|--|---|--|--|--|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |   |   |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |   |
| 1. DECEASED-NAME (Type or print)  |  | First  |  | Middle  |  | Last   |  | 2a. DATE OF DEATH                                       |   |
| John  |  | L.   |  | Capps   |  | 10/8/  |  | Day 1968 Year   |   |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |  | 2b. HOUR  |   |
| Male  |  | White  |  | August 12 1913  |  | 55   |  | M   |   |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |   |
| N.C.  |  | U.S.A.   |  |   |  | Prince George's  |  | Md.   |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |   |
| Cheverly  |  | Prince George's  |  | Retired   |  |  |  |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                                  |   |
| Maryland  |  | Prince George's  |  | College   |  |  |  | 5028 Paduch Rd.   |   |
| 14. FATHER'S NAME   |  | First  |  | Middle  |  | Last   |  | 15. MOTHER'S MAIDEN NAME                                |   |
| John  |  | T.   |  | Capps   |  |  |  | Jennie House  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | Address   |   |
| Yes   |  | WWII   |  | 578 09 1837   |  | Eleanor Capps  |  | Same as above   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>causes of larynx cancer</u><br>1619 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastases</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>161x  |  |  |  |   |  |  |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |   |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION   |  | Street or R.F.D. No.   |  | City or Town County State                               |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>62</u> , to <u>Nov 2/8</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |   |
| 22b. SIGNATURE <u>T. Bergemann</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  |   |  | 22c. DATE SIGNED 10/8/1968 4PM   |  |   |   |
| 22d. PHYSICIAN'S NAME (Type) <u>Till Bergemann M.D.</u>   |  |  |  |   |  | 22e. ADDRESS <u>Greenbelt, Maryland</u>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |   |   |
| Burial  |  | 10/9/1968  |  | Fort Lincoln Cemetery   |  | Colmar Manor, Maryland   |  |   |   |
| 24. FUNERAL DIRECTOR ADDRESS <u>Valley's Funeral Home Mt. Rainier, Md.</u>  |  |  |  |   |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                              |   |
|   |  |  |  |   |  | DATE <u>OCT 10 1968</u>  |  | <u>Charles Judge</u>                                    |   |

12228

12228

12228

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Film 406  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14830

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14839

|   |                         |  |  |  |  |
|---|-------------------------|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)<br>First Middle Last<br><b>Daniel Timothy Carroll</b>   |                         |  | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 10-10-68 1911:45am                          |  | 2b. HOUR   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Negro</b> | 5. DATE OF BIRTH<br><b>5-25-1968</b>   | 6. AGE (In years last birthday)<br>YRS. <b>4</b> MONTHS <b>15</b> DAYS <b>15</b> HOURS <b>15</b> MIN.              | 2c. DATE PRONOUNCED DEAD<br>Month <b>10</b> Day <b>10</b> Year <b>68</b> 12:15pm   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince George General Hosp.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>None</b> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Prince George's</b>   |                         |  | 13b. CITY OR TOWN<br><b>Glenn Arden</b>  |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                      |
| 14. FATHER'S NAME First Middle Last<br><b>James Lyles</b>   |                         |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Dorothy Ramsey</b>  |  | 13d. STREET AND NUMBER<br><b>8621 Leslie Avenue</b>  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |                         |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT ADDRESS<br><b>Dorothy R. Carroll Same as 13e</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Undetermined</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SDII</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>7969</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |                         |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>795.5</b>   |                         |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>795.5</b>  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b> P.M.             |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |  |  |  |  |
| ACTUAL SIGNATURE<br><b>John Kehoe</b>   |                         | M.D.   |  | 22b. DATE SIGNED<br><b>10-11-68</b>  |  |
| EXAMINER'S NAME (Type)<br><b>John Kehoe MD</b>  |                         | RIVERDALE, Md.   |  | ADDRESS (Street, city, town, or county)  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>10-14-68</b>  |                         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Olivet Cem.</b>  |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Washington D.C.</b>   |                         | 23e. REC'D BY REGISTRAR<br><b>OCT 17 1968</b>                                |  | 23f. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

81-15106



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 407 MARYLAND STATE DEPARTMENT OF HEALTH  
12-2-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14831

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14840

|  |  |         |                   |   |  |   |  |   |                |                                |  |  |  |          |  |                            |  |  |  |
|--|--|---------|-------------------|---|--|---|--|---|----------------|--------------------------------|--|--|--|----------|--|----------------------------|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)  |  |         | First Middle Last |   |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED |  |   | Month Day Year |                                |  | 2b. HOUR   |  |          |  |                            |  |  |  |
| Meta   |  |         | Louise            |   |  | Casey                                     |  |   | 10-28-68       |                                |  | 195:50pm   |  |          |  |                            |  |  |  |
| 3. SEX   |  | 4. RACE |                   | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>lost birthday)        |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                | IF UNDER 24 HRS.<br>HOURS MIN. |  | 2c. DATE PRONOUNCED DEAD   |  | 2d. HOUR |  |                            |  |  |  |
| Female   |  | White   |                   | 5-21-1924   |  | 44 YRS.                                   |  |   |                |                                |  | Month Day Year   |  | 6:00pm   |  |                            |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  |         |                   | 7b. CITIZEN OF WHAT COUNTRY?  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           |                |                                |  | 9. COUNTY OF DEATH   |  |          |  |                            |  |  |  |
| New York   |  |         |                   | U S A   |  |   |  |   |                |                                |  | Prince George's Md.  |  |          |  |                            |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         |                   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |                |                                |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |          |  |                            |  |  |  |
| Cheverly   |  |         |                   | Prince George Hospital  |  |   |  | Housewife   |                |                                |  | Own home   |  |          |  |                            |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  |         |                   | 13b. COUNTY   |  |   |  | 13c. CITY OR TOWN   |                |                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  | 13e. STREET AND NUMBER     |  |  |  |
| Maryland   |  |         |                   | Prince George's   |  |   |  | Bowie   |                |                                |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                             |  |          |  | 2505 Knight Hill Lane      |  |  |  |
| 14. FATHER'S NAME  |  |         |                   | 15. MOTHER'S MAIDEN NAME  |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |                |                                |  | 16b. SOCIAL SECURITY NO.   |  |          |  | 17. INFORMANT              |  |  |  |
| First Middle Last  |  |         |                   | First Middle Last   |  |   |  | no  |                |                                |  | 132 16 7846  |  |          |  | Frederick J. Casey         |  |  |  |
| John R Eimann  |  |         |                   | Helen McNamee   |  |   |  |   |                |                                |  |  |  |          |  | Bowie, Md.                 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4129 Heart failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Arteriosclerotic heart disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave<br>rise to immediate cause (a).<br>stating the underlying cause<br>last.   |  |         |                   |   |  |   |  |   |                |                                |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |  |          |  |                            |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>4200  |  |         |                   |   |  |   |  |   |                |                                |  |  |  |          |  |                            |  |  |  |
| 19a. DATE OF OPERATION   |  |         |                   | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                            |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                |                                |  |  |  |          |  |                            |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  |         |                   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.                          |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                |                                |  |  |  |          |  |                            |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |         |                   | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                |                                |  |  |  |          |  |                            |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |         |                   |   |  |   |  |   |                |                                |  |  |  |          |  |                            |  |  |  |
| ACTUAL<br>SIGNATURE  |  |         |                   | M.D.  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |                |                                |  | 22b. DATE SIGNED<br>10-29-68   |  |          |  |                            |  |  |  |
| EXAMINER'S<br>NAME (Type)  |  |         |                   | John Kehoe MD. Riverdale, Md.   |  |   |  | ADDRESS(Street, city, town, or county)  |                |                                |  |  |  |          |  |                            |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  |         |                   | 23b. DATE   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |                |                                |  | 23d. LOCATION (City or Town) (County) (State)  |  |          |  |                            |  |  |  |
| Burial   |  |         |                   | Nov 1, 1968   |  |   |  | St Joseph's Cemetery  |                |                                |  | Boston Suffolk Mass.   |  |          |  |                            |  |  |  |
| 24. FUNERAL DIRECTOR   |  |         |                   |   |  |   |  | ADDRESS   |                |                                |  | 25a. REC'D BY REGISTRAR  |  |          |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |
| F. Gasch's Sons Hyattsville, Md.   |  |         |                   |   |  |   |  |   |                |                                |  | NOV 1 1968   |  |          |  | Charles Judge              |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 14832   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  | CERTIFICATE OF DEATH   |  | 14841  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  | First Middle Last  |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| Cassie  |  | B. Cash  |  | October 11, 1968   |  | 12:45 P.M.   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  |
| Female  |  | Negro  |  | 7/1/1908   |  | 60 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |  | 9. COUNTY OF DEATH   |  |
| North Carolina  |  | U.S.A.   |  | Prince Georges   |  | Md.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Glenn Dale  |  | Glenn Dale Hospital  |  | Domestic   |  | --   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| D.C.  |  | Washington   |  | 1207 New Jersey Ave. N.W.  |  |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  | 16b. SOCIAL SECURITY NO.   |  |
| John  |  | Missie   |  | No   |  | 237-052654   |  |
| 17. INFORMANT   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 19. DATE OF OPERATION  |  | 20a. AUTOPSY?  |  |
| Decedent  |  | PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of cervix with metastases</b>  |  | 19a. DATE OF OPERATION   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
|   |  | (b) _____  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
|   |  | (c) _____  |  | 20c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |
|   |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  |
|   |  | <b>Chronic urinary tract infection.</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  | 21d. INJURY OCCURRED   |  |
|   |  |  |  | 21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  | 21f. LOCATION  |  |
|   |  |  |  | 21g. CITY OR TOWN  |  | 21h. COUNTY  |  |
|   |  |  |  | 21i. STATE   |  |  |  |
|   |  |  |  | 22a. I certify that (he) (this hospital) attended the deceased from <u>4/24/</u> <u>1968</u> , to <u>10/11/</u> <u>1968</u> , that (he) (we) lost the deceased on <u>10/11/68</u> <u>19</u> , and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE   |  |
|   |  |  |  | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (Type)   |  |
|   |  |  |  | 10/11/1968   |  | Moe Weiss, M.D.  |  |
|   |  |  |  | 22e. ADDRESS   |  | 22f. ADDRESS   |  |
|   |  |  |  | Glenn Dale Hospital  |  | Glenn Dale, Maryland   |  |
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|   |  |  |  | 22mr. ADDRESS  |  | 22ms. ADDRESS  |  |
|   |  |  |  | 22mt. ADDRESS  |  | 22mu. ADDRESS  |  |
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|   |  |  |  | 22mz. ADDRESS  |  | 22na. ADDRESS  |  |
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|   |  |  |  | 22nd. ADDRESS  |  | 22ne. ADDRESS  |  |
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|   |  |  |  | 22nk. ADDRESS  |  | 22nl. ADDRESS  |  |
|   |  |  |  | 22nm. ADDRESS  |  | 22no. ADDRESS  |  |
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World Library - 1965

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14833

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14842

|   |         |                  |  |                 |      |  |      |                          |   |  |           |  |  |  |
|---|---------|------------------|--|-----------------|------|--|------|--------------------------|---|--|-----------|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)   |         |                  | First Middle Last  |                 |      | 2a. DATE KNOWN OF DEATH  |      |                          | Month Day Year  |  |           | 2b. HOUR                                 |  |  |
| Charles Donald Catterton  |         |                  |  |                 |      | 10-28-68   |      |                          | 1928  |  |           | 4:00am                                   |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years last birthday)  | IF UNDER 1 YEAR |      | IF UNDER 24 HRS.   |      | 2c. DATE PRONOUNCED DEAD |   |  | 2d. HOUR  |  |  |  |
| Male  | White   | 5-28-1940        | 28 YRS.  | MONTHS          | DAYS | HOURS  | MIN. | 10-28-68                 |   |  | 1928:40am |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |         |                  | 7b. CITIZEN OF WHAT COUNTRY?   |                 |      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |                          | 9. COUNTY OF DEATH  |  |           | Md.                                      |  |  |
| Maryland  |         |                  | USA  |                 |      |  |      |                          | Prince George's   |  |           |  |  |  |
| 10. CITY OR TOWN OF DEATH   |         |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                 |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |      |                          | 12b. KIND OF BUSINESS OR INDUSTRY   |  |           |  |  |  |
| Cheverly  |         |                  | Prince George Hospital   |                 |      | Carpenter  |      |                          | Construction  |  |           |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                  | 13b. COUNTY  |                 |      | 13c. CITY OR TOWN  |      |                          | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |           | 13e. STREET AND NUMBER                   |  |  |
| Maryland  |         |                  | Prince George's  |                 |      | District Heights   |      |                          | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  |           | 2410 Rochelle Avenue                     |  |  |
| 14. FATHER'S NAME   |         |                  | 15. MOTHER'S MAIDEN NAME   |                 |      |  |      |                          |   |  |           |  |  |  |
| Sommers   |         |                  | O'Dell   |                 |      | Beulah   |      |                          | Catterton   |  |           |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |                  | 16b. SOCIAL SECURITY NO.   |                 |      | 17. INFORMANT  |      |                          | ADDRESS   |  |           |  |  |  |
| - Yes -   |         |                  | 1961 - 1965  |                 |      | 217-38-5958  |      |                          | Mrs Beulah Wilkerson  |  |           | 9710 GlenView Drive<br>Clinton, Maryland |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |                  |  |                 |      |  |      |                          |   |  |           |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |         |                  |  |                 |      |  |      |                          |   |  |           |  |  |  |
| IMMEDIATE CAUSE (a) Laceration of brain   |         |                  |  |                 |      |  |      |                          |   |  |           |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF Trauma - auto accident   |         |                  |  |                 |      |  |      |                          |   |  |           |  |  |  |
| (b)   |         |                  |  |                 |      |  |      |                          |   |  |           |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                  |  |                 |      |  |      |                          |   |  |           |  |  |  |
| (c)   |         |                  |  |                 |      |  |      |                          |   |  |           |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |         |                  |  |                 |      |  |      |                          |   |  |           |  |  |  |
| 8234  |         |                  |  |                 |      |  |      |                          |   |  |           |  |  |  |
| 19a. DATE OF OPERATION  |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |                 |      |  |      |                          | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |           |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                  | 21b. TIME OF INJURY Month, Day, Year   |                 |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |      |                          |   |  |           |  |  |  |
|   |         |                  | 9:57pm 10-24-1968  |                 |      | tree. Driver of car which ran off road and struck a  |      |                          |   |  |           |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |         |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                 |      | 21f. LOCATION Street or R.F.D. No. City or Town County State   |      |                          |   |  |           |  |  |  |
|   |         |                  | Enterprise Rd., s miles  |                 |      | south of Rt. 450, Mitchellville, P.G. Co., Md.   |      |                          |   |  |           |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                  |  |                 |      |  |      |                          |   |  |           |  |  |  |
| ACTUAL SIGNATURE  |         |                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                              |                 |      |  |      |                          | 22b. DATE SIGNED  |  |           |  |  |  |
| EXAMINER'S NAME (Type)  |         |                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                          |                 |      |  |      |                          | 10-28-68  |  |           |  |  |  |
| John Kehoe MD   |         |                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                  |                 |      |  |      |                          | ADDRESS(Street, city, town, or county)  |  |           |  |  |  |
| Riverdale, Md.  |         |                  |  |                 |      |  |      |                          |   |  |           |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |                  | 23b. DATE  |                 |      | 23c. NAME OF CEMETERY OR CREMATORY   |      |                          | 23d. LOCATION (City or Town) (County) (State)                                     |  |           |  |  |  |
| Burial  |         |                  | Oct. 31, 1968  |                 |      | Mt. Harmony Chr. Cemetery Owings   |      |                          | Calvert Maryland  |  |           |  |  |  |
| 24. FUNERAL DIRECTOR  |         |                  | ADDRESS  |                 |      |  |      |                          | 25a. REC'D BY REGISTRAR   |  |           |  |  |  |
| Hutchins Funeral Home   |         |                  | Owings, Maryland   |                 |      |  |      |                          | 25b. REGISTRAR'S SIGNATURE  |  |           |  |  |  |
|   |         |                  | DATE OCT 31 1968   |                 |      |  |      |                          | Charles Judge   |  |           |  |  |  |

5824

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14836

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14843

|   |  |  |   |   |  |   |  |                                |   |                                |   |  |  |  |
|---|--|--|---|---|--|---|--|--------------------------------|---|--------------------------------|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>LUCILE S. CAWTHORNE</b>  |  |  | 2a. DATE OF DEATH<br>October 11 Day 1968  |   |  | 2b. HOUR<br>M   |  |                                |   |                                |   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White                       |   | 5. DATE OF BIRTH<br>July 16 1878  |  | 6. AGE (In years<br>last birthday)<br>90 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS.<br>HOURS MIN. |   |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Ga.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Prince George's Md.   |  |                                |   |                                |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Mt. Rainier  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>3806 33rd Street |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Clerk |  |                                | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Drug  |                                |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland  |  |  | 13b. COUNTY<br>Prince George's  |   |  | 13c. CITY OR TOWN<br>Mt. Rainier  |  |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                |   | 13e. STREET AND NUMBER<br>3806 33rd Street |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>William B. Stockman   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Mary Etta Shaw                                     |   |  |   |  |                                |   |                                |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>NO   |  |  | 16b. SOCIAL SECURITY NO.<br>(If not give war or dates of service)<br>None                           |   |  | 17. INFORMANT<br>George S Cawthorne   |  |                                | Address<br>Washington, D.C.   |                                |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute cerebral thrombosis</u><br>4339<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>cerebral arteriosclerosis</u><br>332x   |  |  |   |   |  |   |  |                                |   |                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |   |  |   |  |                                |   |                                |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |  |                                | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |                                |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                     |  |                                |   |                                |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                     |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |                                |   |                                |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 1967, to <u>Oct 11</u> , 1968, that (I) (we) last<br>saw the deceased alive on <u>Sept 13</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |  |                                |   |                                |   |  |  |  |
| 22b. SIGNATURE<br><u>Don B. Cameron</u> DEGREE  |  |  | ATTENDING<br>PHYS. <input checked="" type="checkbox"/>  |   |  | MED.<br>DIRECTOR <input type="checkbox"/>   |  |                                | STAFF<br>PHYS. <input type="checkbox"/>   |                                |   | 22c. DATE SIGNED<br><u>Oct 11, 1968</u>    |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><u>DON B. CAMERON</u>  |  |  | 22e. ADDRESS<br>Mt. Rainier, Maryland   |   |  |   |  |                                |   |                                |   |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br><u>10/14/1968</u>  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Fort Lincoln Cemetery</u>                                  |  |                                | 23d. LOCATION (City or Town) (County) (State)<br><u>Colmar Manor, Maryland</u>                  |                                |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><u>Nalley's Funeral Home Mt. Rainier, Md</u>   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>OCT 15 1968</u>  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |                                |   |                                |   |  |  |  |

MEDICAL CERTIFICATION

60341

1930

1931

1931



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 5 & 6 Film 4106

11/14/68 kk

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14835

CERTIFICATE OF DEATH

14844

|  |  |  |  |   |          |   |   |   |   |  |                 |
|--|--|--|--|---|----------|---|---|---|---|--|-----------------|
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  | Middle  | Last     | 2a. DATE OF DEATH   |   |   | 2b. HOUR  |  |                 |
| Theodore   |  |  | John   |   | Chaconas | 10  | 31  | 68  | M   |  |                 |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |          |   | 6. AGE (In years last birthday)               |   | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS |
| Male   |  | White  |  | Oct. 2, 1902  |          |   | 66 67 YRS.                                    |   | MONTHS  | DAYS   | HOURS MIN.      |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |          |   | 9. COUNTY OF DEATH                            |   |   |  |                 |
| D.C.   |  | U.S.A.   |  |   |          |   | Prince Georges Md.                            |   |   |  |                 |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                 |
| Hyattsville  |  |  | Prince George Gen.   |   |          | Retired   |   |   |   |  |                 |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   |          | 13c. CITY OR TOWN   |   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                 |
| Md.  |  |  | Prince George  |   |          | Bladensburg   |   |   | 6011 Emerson St.  |  |                 |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |   |          |   |   |   |   |  |                 |
| First Middle Last  |  |  | First Middle Last  |   |          |   |   |   |   |  |                 |
| Peter J. Chaconas  |  |  | Dianna Rony  |   |          |   |   |   |   |  |                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |   |          | 17. INFORMANT   |   |   | Address   |  |                 |
| No   |  |  |  |   |          | Frieda Chaconas   |   |   | Same as 13c & e   |  |                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>arteriosclerotic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |  |   |          |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>4201</u>  |  |  |  |   |          |   |   |   |   |  |                 |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |  |                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |   |          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |   |   |   |  |                 |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   |          | 21f. LOCATION   |   | Street or R.F.D. No.  |   | City or Town County State                    |                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> , to <u>Oct 3</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Aug 28</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |  |  |   |          |   |   |   |   |  |                 |
| 22b. SIGNATURE<br><u>Don B. Cameron</u>  |  |  |  |   |          | DEGREE  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br>Nov. 1, 1968             |                 |
| 22d. PHYSICIAN'S NAME (Type)<br>Don B. Cameron M.D.  |  |  |  |   |          | 22e. ADDRESS<br>3503 Perry St. Mt. Rainer, Md.  |   |   |   |  |                 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |          |   | 23d. LOCATION (City or Town) (County) (State) |   |   |  |                 |
| Cremation  |  | 11/1/68  |  | Lee's Crematory   |          |   | Washington, D.C. 20002                        |   |   |  |                 |
| 24. FUNERAL DIRECTOR   |  |  |  |   |          | ADDRESS   |   | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE                   |                 |
| Lee Funeral Home   |  |  |  |   |          | Washington, D.C.  |   | DATE NOV 4 1968   |   | <u>Charles Judge</u>                         |                 |

14814

STATEMENT OF DEBIT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14836

CERTIFICATE OF DEATH

14845

|  |  |  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <u>Thomas</u>  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH<br>10 Month 11 Day 1968 Year  |  |  | 2b. HOUR<br>10 P M   |  |  |
| 3. SEX<br><u>Male</u>  |  |  | 4. RACE<br><u>Negro</u>  |  |  | 5. DATE OF BIRTH<br>9/10/1889   |  |  | 6. AGE (In years last birthday)<br>79 YRS.   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><u>Prince Georges</u> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Clinton, MD.</u>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>Pine View Gardens</u> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><u>Laborer</u>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><u>DC MD</u>  |  |  | 13b. COUNTY<br><u>5408 Wheelbar Rd SE</u>  |  |  | 13c. CITY OR TOWN<br><u>Wash DC</u>   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br><u>5408 Wheelbar Rd SE</u>   |  |  | 14. FATHER'S NAME<br>First Middle Last<br><u>Chase</u>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><u>Maggie ?</u>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.<br><u>578-10-048</u>  |  |  | 17. INFORMANT<br><u>San Thomas Chase Jr.</u>  |  |  | Address<br><u>Same</u>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u><br><u>4119</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>vascular collapse</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><u>4201</u>  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 1968   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 10</u> , 19 <u>68</u> , to <u>Oct 11</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct 11</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                   |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Garry G. Gandy</u>  |  |  | DEGREE<br><u>MD</u>  |  |  | ATTENDING PHYS.<br><input checked="" type="checkbox"/>  |  |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>H. J. HADLEY</u>  |  |  | 22e. ADDRESS<br><u>4601 Nichols Ave SE</u>   |  |  | 22c. DATE SIGNED<br><u>Oct 68</u>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify)<br><u>Burial</u>  |  |  | 23b. DATE<br><u>10/15/68</u>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Olivet Cemetery</u>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Washington, D.C.</u>                     |  |  |
| 24. FUNERAL DIRECTOR<br><u>John T. Stewart</u>   |  |  | 25a. REC'D BY REGISTRAR<br><u>Stewart Funeral Home-4001 Benning Rd.</u>                                  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  | DATE<br><u>OCT 15 1968</u>   |  |  |

14889

14889

14889

14889

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 14837 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |                  |  |                 |                                    |  |   |                          |   | 14846  |          |
|---|---------|------------------|--|-----------------|------------------------------------|--|---|--------------------------|---|--|----------|
| Item 86, Film 405 10/16/68 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |                  |  |                 |                                    |  |   |                          |   |  |          |
| 1. DECEASED-NAME<br>(Type or Print)   |         |                  | First Middle Last  |                 |                                    | 2a. DATE KNOWN OF DEATH  |   |                          | 2b. HOUR  |  |          |
| James Edward Christian  |         |                  |  |                 |                                    | Month 3 Day 3 Year 68  |   |                          | 2:00 PM   |  |          |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years)  | IF UNDER 1 YEAR |                                    | IF UNDER 24 HRS.   |   | 2c. DATE PRONOUNCED DEAD |   |  | 2d. HOUR |
| M   | W       | 4 Dec. 68        | 95   | MONTHS          | DAYS                               | HOURS  | MIN.  | Month 10 Day 3 Year 68   | 2:00 PM   |  |          |
| 7a. BIRTH PLACE (State or foreign country)  |         |                  | 7b. CITIZEN OF WHAT COUNTRY?   |                 |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |                          | 9. COUNTY OF DEATH  |  |          |
| Greenville, Va.   |         |                  | USA  |                 |                                    |  |   |                          | Prince George Md.   |  |          |
| 10. CITY OR TOWN OF DEATH   |         |                  | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) |                 |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   |                          | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |          |
| Clinton   |         |                  | Clinton Comm. Hospital   |                 |                                    |  |   |                          |   |  |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                  | 13b. COUNTY  |                 |                                    | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |                          | 13e. STREET AND NUMBER  |  |          |
| Washington  |         |                  | Dist of Columbia   |                 |                                    |  |   |                          | 1634 Gale St. N.E.  |  |          |
| 14. FATHER'S NAME   |         |                  | 15. MOTHER'S MAIDEN NAME   |                 |                                    |  |   |                          |   |  |          |
| First Middle Last   |         |                  | First Middle Last  |                 |                                    |  |   |                          |   |  |          |
| Thomas Christian  |         |                  | IRENE GRATEN   |                 |                                    |  |   |                          |   |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |                  | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service)               |                 |                                    | 17. INFORMANT  |   |                          | ADDRESS   |  |          |
|   |         |                  |  |                 |                                    | Alberta Christian  |   |                          | W - Same as above   |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |                  |  |                 |                                    |  |   |                          |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART I. DEATH WAS CAUSED BY:  |         |                  |  |                 |                                    |  |   |                          |   |  |          |
| IMMEDIATE CAUSE (a)   |         |                  |  |                 |                                    |  |   |                          |   | Minutes                                      |          |
| DUE TO, OR AS A CONSEQUENCE OF Heart failure  |         |                  |  |                 |                                    |  |   |                          |   |  |          |
| (b)   |         |                  |  |                 |                                    |  |   |                          |   |  |          |
| DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease   |         |                  |  |                 |                                    |  |   |                          |   | 2 yrs  |          |
| (c)   |         |                  |  |                 |                                    |  |   |                          |   |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |                  |  |                 |                                    |  |   |                          |   |  |          |
| 4200 Diabetes mellitus-over 2 yrs.  |         |                  |  |                 |                                    |  |   |                          |   |  |          |
| 19a. DATE OF OPERATION  |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |                 |                                    |  |   |                          | 20. AUTOPSY?  |  |          |
|   |         |                  |  |                 |                                    |  |   |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>   |         |                  | 21b. TIME OF INJURY Month, Day, Year   |                 |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |                          |   |  |          |
| CAUSE OF DEATH  |         |                  | P.M. 19  |                 |                                    |  |   |                          |   |  |          |
| 21d. INJURY OCCURRED  |         |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                 |                                    | 21f. LOCATION Street or R.F.D. No.   |   |                          | City or Town County State   |  |          |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         |                  |  |                 |                                    |  |   |                          |   |  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |                  |  |                 |                                    |  |   |                          |   |  |          |
| ACTUAL SIGNATURE  |         |                  | EXAMINER'S NAME (Type)   |                 |                                    | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |                          | 22b. DATE SIGNED  |  |          |
| John Kehoe  |         |                  | John Kehoe, M.D. Riverdale   |                 |                                    | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |                          | 10-3-64   |  |          |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |         |                  | ADDRESS (Street, city, town, or county)                                      |                 |                                    |  |   |                          |   |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |                  | 23b. DATE  |                 | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION (City or Town) (County) (State) |                          |   |  |          |
| Burial  |         |                  | 10-7-68  |                 | John Wesley Church                 |  | Aguasca, Md. Pr. Geo. Co.                     |                          |   |  |          |
| 24. FUNERAL DIRECTOR  |         |                  | 25a. REC'D BY REGISTRAR  |                 |                                    | 25b. REGISTRAR'S SIGNATURE   |   |                          |   |  |          |
| Martell Adams   |         |                  | Aguasca, Md.   |                 |                                    | OCT 11 1968  |   |                          | Charles Judge   |  |          |



11826

11827

James, John  
A. Dec. 1902  
11826

Prince George  
List of Columns  
11827

Heart Failure  
Arteriosclerotic heart disease  
Diabetes mellitus-over 2 yrs.

John Jones, M.D.  
11828

OCT 11 1958



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |       |   |         |   |      |  |  |   |                           |                                     |  |
|---|--|---|-------|---|---------|---|------|--|--|---|---------------------------|-------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |       |   |         |   |      |  |  |   |                           |                                     |  |
| CERTIFICATE OF DEATH  |  |   |       |   |         |   |      |  |  |   |                           |                                     |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First |   | Middle  |   | Last |  | 2a. DATE OF DEATH<br>Month 10 Day 15 Year 68 |   | 2b. HOUR<br>11:10<br>a.m. |                                     |  |
| Frank   |  |   | T.    |   | Cinotti |   |      |  |  |   |                           |                                     |  |
| 3. SEX  |  | 4. RACE   |       | 5. DATE OF BIRTH  |         |   |      | 6. AGE (In years<br>last birthday)   |  | IF UNDER 1 YEAR   |                           | IF UNDER 24 HRS.                    |  |
| Male  |  | White   |       | Nov. 23, 1899   |         |   |      | 68   |  | MONTHS  |                           | DAYS                                |  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |         | 9. COUNTY OF DEATH  |      |  |  |   |                           |                                     |  |
| Wash., D.C.   |  | U.S.A.  |       |   |         | Prince George Co. Md.   |      |  |  |   |                           |                                     |  |
| 10. CITY OR TOWN OF DEATH   |  |   |       | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)   |         |   |      | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |                           |                                     |  |
| West Hyattsville  |  |   |       | 6417 Sligo Parkway  |         |   |      | Contractor   |  | Stone & Brick   |                           |                                     |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |  |   |       | 13b. COUNTY   |         | 13c. CITY OR TOWN   |      | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET AND NUMBER  |                           |                                     |  |
| Md.   |  |   |       | Pr. George  |         | W. Hyatts.  |      | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |  | 6417 Sligo Parkway  |                           |                                     |  |
| 14. FATHER'S NAME   |  |   |       | First   |         | Middle  |      | Last   |  | 15. MOTHER'S MAIDEN NAME  |                           |                                     |  |
| John  |  |   |       | B.  |         | Cinotti   |      |  |  | Louise T. Zacarin   |                           |                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  |   |       | 16b. SOCIAL SECURITY NO.  |         | 17. INFORMANT   |      | Address  |  |   |                           |                                     |  |
| Unk.  |  |   |       |   |         | Cecilia M. Cinotti-wife   |      | Same as #13  |  |   |                           |                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the Liver</u><br><u>1978</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |       |   |         |   |      |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>23 days</u>   |                           |                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>1561</u>  |  |   |       |   |         |   |      |  |  |   |                           |                                     |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |       |   |         | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |      | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                    |  |   |                           |                                     |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |         |   |      |  |  |   |                           |                                     |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |       | 21f. LOCATION   |         | Street or R.F.D. No.  |      | City or Town   |  | County  |                           | State                               |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>11/9</u> , 19 <u>48</u> , to <u>Oct. 15</u> , 19 <u>68</u> , that (I) (we) last<br>saw the deceased alive on <u>Oct. 15</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |       |   |         |   |      |  |  |   |                           |                                     |  |
| 22b. SIGNATURE <u>Thomas F Collins</u>  |  |   |       |   |         |   |      | DEGREE   |  | ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |                           | 22c. DATE SIGNED<br><u>10/15/68</u> |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <u>Thomas F Collins, M.D.</u>   |  |   |       |   |         |   |      | 22e. ADDRESS<br><u>2600 Queens Chapel Road, Hyatts-<br/>ville, Maryland</u>                |  |   |                           |                                     |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE   |       | 23c. NAME OF CEMETERY OR CREMATORY  |         | 23d. LOCATION (City or Town)  |      | (County)   |  | (State)   |                           |                                     |  |
| Burial  |  | Oct. 18, 1968   |       | Fort Lincoln Cem.   |         | Colmar Manor, Maryland  |      |  |  |   |                           |                                     |  |
| 24. FUNERAL DIRECTOR  |  |   |       |   |         | ADDRESS   |      | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |                           |                                     |  |
| Lee Fun. Home-300 4th St. NE Wash., D.C.  |  |   |       |   |         |   |      | DATE <u>OCT 18 1968</u>  |  | <u>Charles Judge</u>  |                           |                                     |  |

14847

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CHURCH OF CHRIST

Class

Nov. 22, 1922

Address

Church of Christ

Church of Christ

Address

Church of Christ

Church of Christ

Church of Christ

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VR A 15  
30M REV 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |                          |  |  |  |                                 |  |                    |  |                  |  |
|--|--|--|--------------------------|--|--|--|---------------------------------|--|--------------------|--|------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |                          |  |  |  |                                 |  |                    |  |                  |  |
| CERTIFICATE OF DEATH   |  |  |                          |  |  |  |                                 |  |                    |  |                  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last        |  |  | 2a. DATE OF DEATH  |                                 |  | 2b. HOUR           |  |                  |  |
| Harold J. Clay   |  |  |                          |  |  | Oct. - 23 - 1968   |                                 |  | 4:05 <sup>PM</sup> |  |                  |  |
| 3. SEX   |  | 4. RACE  |                          | 5. DATE OF BIRTH   |  |  | 6. AGE (In years last birthday) |  | IF UNDER 1 YEAR    |  | IF UNDER 24 HRS. |  |
| male   |  | white  |                          | Jan. 18, 1892  |  |  | 76 YRS.                         |  | MONTHS DAYS        |  | HOURS MIN.       |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH                                       |                                 |  |                    |  |                  |  |
| Minn.  |  | U.S.A.   |                          |  |  | Prince George Md.  |                                 |  |                    |  |                  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |                          | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |  |  |                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |                    | 12b. KIND OF BUSINESS OR INDUSTRY            |                  |  |
| Nyattsville  |  |  |                          | Nyattsville Nursing Home   |  |  |                                 | Ret. Marketing Spec. Agriculture Dept.   |                    | N.E.   |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |                          | 13b. COUNTY  |  | 13c. CITY OR TOWN  |                                 | 13d. INSIDE CITY BLOCK AND NUMBER  |                    | 13e. STREET AND NUMBER                       |                  |  |
| Wash. D.C.   |  |  |                          |  |  | Wash. D.C.   |                                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |                    | 2603 Monroe St.                              |                  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME |  |  |  |                                 |  |                    |  |                  |  |
| First Middle Last  |  |  | First Middle Last        |  |  |  |                                 |  |                    |  |                  |  |
| William Clay   |  |  | Ruth S. Johnson          |  |  |  |                                 |  |                    |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)   |  |  |                          | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address                                    |                                 |  |                    |  |                  |  |
| yes  |  |  |                          | 578-56-5341  |  | Bessie E. Clay same as above                             |                                 |  |                    |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |                          |  |  |  |                                 |  |                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary artery thrombosis   |  |  |                          |  |  |  |                                 |  |                    |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |                          |  |  |  |                                 |  |                    |  |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |                          |  |  |  |                                 |  |                    |  |                  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |  |  |                          |  |  |  |                                 |  |                    |  |                  |  |
| (c) coronary artery thrombosis   |  |  |                          |  |  |  |                                 |  |                    |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |                          |  |  |  |                                 |  |                    |  |                  |  |
| 4201 diabetes mellitus   |  |  |                          |  |  |  |                                 |  |                    |  |                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |  |  | 20a. AUTOPSY?  |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                   |                    |  |                  |  |
|  |  |  |                          |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |                                 |  |                    |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |                                 |  |                    |  |                  |  |
|  |  | HOUR A.M. Month Day Year P.M. 19   |                          |  |  |  |                                 |  |                    |  |                  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION  |  | Street or R.F.D. No.                                     |                                 | City or Town   |                    | County State                                 |                  |  |
| While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |                          |  |  |  |                                 |  |                    |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 1968, to Oct 23 1968, that (I) (we) last saw the deceased alive on Oct 5 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                          |  |  |  |                                 |  |                    |  |                  |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |                          |  |  |  |                                 |  |                    |  |                  |  |
| Don B. Cameron   |  | 10-23-68   |                          |  |  |  |                                 |  |                    |  |                  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |                          |  |  |  |                                 |  |                    |  |                  |  |
| Don B. Cameron   |  | 3503 Perry St.-Mt. Rainier, Md.  |                          |  |  |  |                                 |  |                    |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town)                             |                                 | (County)   |                    | (State)                                      |                  |  |
| Burial   |  | 10/25/68   |                          | Ft. Lincoln Cemetery   |  | Prince Georges Co.                                       |                                 | Md.  |                    |  |                  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. REC'D BY REGISTRAR  |                          | 25b. REGISTRAR'S SIGNATURE   |  |  |                                 |  |                    |  |                  |  |
| The S.H. Hines Co  |  | DATE   |                          | OCT 24 1968  |  | Charles Judge  |                                 |  |                    |  |                  |  |
| Washington, D. C.  |  |  |                          |  |  |  |                                 |  |                    |  |                  |  |

MEDICAL CERTIFICATION

14848

STATEMENT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14849

|  |  |   |   |  |
|--|--|---|---|--|
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>MAGGIE V CLUTTER</b>  |  | 2a. DATE OF DEATH Month 10 Day 9 Year 68  |   | 2b. HOUR<br>7:30 A M                           |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>2/26/1884   |   | 6. AGE (In years last birthday)<br>84 YRS.     |
| 7a. BIRTHPLACE (State or foreign country)<br>West Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. COUNTY OF DEATH<br>Prince Georges Md.   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Oxon Hill   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>5800 Hempstead Dr. |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  | 13b. COUNTY<br>Prince Geo  | 13c. CITY OR TOWN<br>Oxon Hill  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET AND NUMBER<br>5800 Hempstead Drive |
| 14. FATHER'S NAME First Middle Last<br>Doc Mc Million  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Eliza J. Davis  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown) (If yes give war or dates of service)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>236242480   | 17. INFORMANT Address<br>Jessie Woofter LaPlata, Maryland   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>GENERALIZED ASCVD</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4221</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>Recurrent &amp; partial &amp; minor polycystic gland tumors</b>   |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>Sept 11th</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Polycystic tumor</b>                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                       | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 4</b> , 1968, to <b>Oct 9</b> , 1968, that (I) (we) lost the deceased alive on <b>Sept 25</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.  |  |   |   |  |
| 22b. SIGNATURE<br><b>Louis M. Damiano MD</b>   |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED<br><b>10/9/68</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>LOUIS M. DAMIANO</b>  |  | 22e. ADDRESS<br><b>6001 Landover Rd</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>10-12-1968</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Suitland Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Robert E. Wilhelm</b>   |  | 24a. ADDRESS<br><b>4308 Suitland Road Suitland Maryland</b>   |   | 25a. REC'D BY REGISTRAR<br><b>OCT 14 1968</b>  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. J. Judge</b>  |   |  |

80041

00370



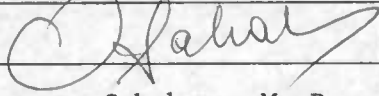

CHIEF-CLERK

80041 00370



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <span>14841</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>14850</span> </div> <div style="text-align: center; font-weight: bold;">CERTIFICATE OF DEATH</div>   |  |  |  |  |  |   |  |  |                                   |  |  |
|---|--|--|--|--|--|---|--|--|-----------------------------------|--|--|
| 1. DECEASED-NAME (Type or print) <b>Mason Howard Cobb</b>   |  |  |  | 2a. DATE OF DEATH <b>Oct. 30, 1968</b> Year  |  |   |  | 2b. HOUR <b>3:50 A</b> M   |                                   |  |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>Caucasian</b>   |  | 5. DATE OF BIRTH <b>Feb. 3, 1920</b>   |  |   |  | 6. AGE (In years last birthday) <b>48</b> YRS.   |                                   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Md</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Prince George's Md.</b>   |  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH <b>Cheverly</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Auto garage self employed</b>                          |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  |  | 13b. COUNTY <b>Prince George's Landover</b>  |  |  | 13c. CITY OR TOWN <b>Landover</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER <b>Church Road, P.O. Box 1241</b> |  |
| 14. FATHER'S NAME First <b>Josias</b> Middle <b>Mason</b> Last <b>Cobb</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>Louise</b> Middle <b>Seauberlich</b> Last  |  |   |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>yes W W II</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>579 12 3358</b>  |  | 17. INFORMANT <b>Ethel A Cobb</b> Address <b>Bladensburg, Md.</b>   |  |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Nutritional cirrhosis of the liver with fatty metamorphosis, advanced.</b><br>5718 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hepatic failure.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |  |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>5810  |  |  |  |  |  |   |  |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>              |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |                                   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |                                   |  |  |
| 22a. I certify that (I) <del>this hospital</del> attended the deceased from <b>Oct 27, 1968</b> , to <b>Oct. 30, 1968</b> , that (I) <del>was</del> lost saw the deceased alive on <b>Oct. 30, 1968</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.                                |  |  |  |  |  |   |  |  |                                   |  |  |
| 22b. SIGNATURE   |  |  |  |  |  | DEGREE <b>MD.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED <b>Oct. 30, 1968</b>  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Ohannes Sahakyan, M. D.</b>   |  |  |  |  |  | 22e. ADDRESS <b>6001 Landover Rd., Cheverly, Md. 20785</b>  |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE <b>Nov 2, 1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>   |  |  |                                   |  |  |
| 24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>   |  |  |  | 25a. REC'D BY REGISTRAR <b>NOV 4 1968</b> DATE   |  | 25b. REGISTRAR'S SIGNATURE                                   |  |  |                                   |  |  |

14830

WINDMILL HILL

14831

1900 1901 1902 1903 1904 1905 1906 1907 1908 1909 1910 1911 1912 1913 1914 1915 1916 1917 1918 1919 1920

1921 1922 1923 1924 1925 1926 1927 1928 1929 1930 1931 1932 1933 1934 1935 1936 1937 1938 1939 1940 1941

1942 1943 1944 1945 1946 1947 1948 1949 1950 1951 1952 1953 1954 1955 1956 1957 1958 1959 1960 1961 1962

1963 1964 1965 1966 1967 1968 1969 1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1980 1981 1982 1983

1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004

2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024

2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045

2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066

2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087

2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108

2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129

2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150

2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171

2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192

2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213

2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234

2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255

2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276

2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

| 14842 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |   |                          |   |         |   |      |  |                          | 14851  |          |
|---|---------|---|--------------------------|---|---------|---|------|--|--------------------------|--|----------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |   |                          |   |         |   |      |  |                          |  |          |
| 1. DECEASED-NAME<br>(Type or Print)   |         |   | First                    |   | Middle  |   | Last |  |                          | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> 10-22-68 19 9:35am |          |
| Ella  |         |   | Mary                     |   | Cookson |   |      |  |                          |  | 2b. HOUR |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  |                          | 6. AGE (In years<br>last birthday)  |         | IF UNDER 1 YEAR<br>MONTHS DAYS            |      | IF UNDER 24 HRS<br>HOURS MIN.  |                          | 2c. DATE PRONOUNCED DEAD<br>Month 10 Day 22 Year 68 10:15am                                      |          |
| Female  | White   | 8-13-1887   |                          | 81 YRS.   |         |   |      |  |                          | 2d. HOUR   |          |
| 7a. BIRTHPLACE (State or foreign<br>country)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |         | 9. COUNTY OF DEATH<br>Prince George's Md. |      |  |                          |  |          |
| Pa  |         | U S A   |                          |   |         | Prince George's                           |      |  |                          |  |          |
| 10. CITY OR TOWN OF DEATH   |         |   |                          | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)   |         |   |      | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |                          | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |          |
| Cheverly  |         |   |                          | Prince George Hospital  |         |   |      | Housewife  |                          | home   |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |         |   |                          | 13b. COUNTY   |         | 13c. CITY OR TOWN                         |      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |                          | 13e. STREET AND NUMBER   |          |
| Maryland  |         |   |                          | Prince George's   |         | Greenbelt                                 |      | YES <input type="checkbox"/> NO <input type="checkbox"/>                                   |                          | 39 G Ridge Road  |          |
| 14. FATHER'S NAME   |         |   | First                    |   | Middle  |   | Last |  | 15. MOTHER'S MAIDEN NAME |  |          |
| Timothy O' Herron   |         |   |                          |   |         |   |      |  | Anna Mary Holleran       |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         |   | 16b. SOCIAL SECURITY NO. |   |         | 17. INFORMANT                             |      |  | ADDRESS                  |  |          |
| no  |         |   | 169 05 4388              |   |         | Charles Joseph Cookson                    |      |  | Greenbelt, Md.           |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Heart failure<br>4129<br>Conditions, if any, which gave<br>rise to immediate cause (a).<br>stating the underlying cause<br>lost.<br>DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |         |   |                          |   |         |   |      |  |                          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>minutes<br>unknown                            |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |   |                          |   |         |   |      |  |                          |  |          |
| 4200  |         |   |                          |   |         |   |      |  |                          |  |          |
| 19a. DATE OF OPERATION  |         |   |                          | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |         |   |      | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |                          |  |          |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                    |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |         |   |      |  |                          |  |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |                          | 21f. LOCATION Street or R.F.D. No.  |         |   |      | City or Town   |                          | County State   |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |   |                          |   |         |   |      |  |                          |  |          |
| ACTUAL<br>SIGNATURE   |         |   |                          | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |         |   |      | 22b. DATE SIGNED   |                          |  |          |
| EXAMINER'S<br>NAME (Type) John Kehoe MD Riverdale, Md.  |         |   |                          | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |         |   |      | 10-22-68   |                          |  |          |
|   |         |   |                          | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |         |   |      | ADDRESS (Street, city, town, or county)  |                          |  |          |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |         | 23b. DATE   |                          | 23c. NAME OF CEMETERY OR CREMATORY  |         |   |      | 23d. LOCATION (City or Town) (County) (State)  |                          |  |          |
| Burial  |         | Oct 25, 1968  |                          | Gate of Heaven cemetery   |         |   |      | Wheaton Montgomery Md.   |                          |  |          |
| 24. FUNERAL DIRECTOR  |         |   |                          | ADDRESS   |         |   |      | 25a. REC'D BY REGISTRAR  |                          | 25b. REGISTRAR'S SIGNATURE   |          |
| F. Gasch's Sons   |         |   |                          | Hyattsville, Md.  |         |   |      | OCT 25 1968  |                          | Charles Judge  |          |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

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|  |  |   |   |  |  |   |  |  |  |
|--|--|---|---|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) <b>PEARL E COUTURE</b>  |  |   | 2a. DATE OF DEATH <b>OCTOBER</b> Month <b>21</b> Day <b>1968</b> Year |  |  | 2b. HOUR <b>5:15</b> PM   |  |  |  |
| 3. SEX <b>FEMALE</b>   |  | 4. RACE <b>CAUCASIAN</b>  |   | 5. DATE OF BIRTH <b>4 Mar 1896</b>   |  | 6. AGE (In years last birthday) <b>72</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                              |  |
| 7a. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>PRINCE GEORGE'S</b> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>ANDREWS AFB</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MALCOLM GROW USAFHOSP</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>NEW YORK STATE WARREN</b>   |  | 13c. CITY OR TOWN <b>GLENS FALLS</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET AND NUMBER <b>RR 1 BOX 138</b>  |  |  |  |
| 14. FATHER'S NAME First Middle Last <b>THEODORE KILMER</b>   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last <b>CLARISSE VAN DUSEN</b>  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown  |  | 16b. SOCIAL SECURITY NO. <b>0-87-01-8682</b>  |   | 17. INFORMANT <b>2046 DORIS RD, AUGUSTA GA</b><br><b>RAYMOND B COUTURE SR</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCT ACUTE</b><br><b>157.9</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>ASPIRATION of gastric contents</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CARCINOMA of the Pancreas</b> |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>1 1/2 years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>157X</b>  |  |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>common duct obstruction</b>                           |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                              |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>16 SEP, 1968</b> , to <b>21 OCT, 1968</b> , that (I) (we) lost the deceased alive on <b>21 OCT 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE <b>W. J. Linn</b>   |  |   |   | DEGREE   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <b>23 Oct 68</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |   |   | 22e. ADDRESS   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE <b>10-24-68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl.</b>  |  | 23d. LOCATION (City or Town) <b>Arlington</b> (County) <b>Va.</b> (State)   |  |  |  |
| 24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home 4308 Suitland Rd. S. E.</b>   |  |   |   | 25a. REC'D BY REGISTRAR <b>NOV 1 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |   |   |  |   |   |  |
|---|--|---|---|---|---|---|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |   |   |  |   |   |  |
| CERTIFICATE OF DEATH  |  |   |   |   |   |   |  |   |   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Rose</b>   |  |   | First <b>ANN</b>  |   |   | Middle <b>COX.</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>10</b> Day <b>28</b> Year <b>1968</b> |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br><b>3-17-86</b>  |   |   | 6. AGE (In years lost birthday)<br><b>82</b> YRS.                        |   | 7b. HOUR<br><b>8:50 AM</b>  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>IRELAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Prince Georges</b> Md.   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Clinton</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Pine View Gardens.</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                     |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>2229 Hindle Lane</b>  |  | 13b. COUNTY<br><b>Prince George</b>   |   | 13c. CITY OR TOWN<br><b>Bowie</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>2229 Hindle Lane</b>     |   |  |
| 14. FATHER'S NAME<br>First <b>John</b> Middle <b>Culligan</b> Last <b>Culligan</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Anne</b> Middle <b>Smith</b> Last <b>Smith</b> |   |   |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>266-24-5437-B</b>  |   | 17. INFORMANT<br>Address <b>Catherine Kirk 2229 Hindle Lane, Bowie Md.</b>  |   |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Circulatory Collapse</b><br><b>4270</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Chronic pulmonary disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary Heart Disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b> |  |   |   |   |   |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>4341</b>   |  |   |   |   |   |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?     |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-10-68</b> , 19 <b>68</b> , to <b>10-28-68</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-28-68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |   |   |   |  |   |   |  |
| 22b. SIGNATURE<br><b>Alfred R. Lapin, MD</b> DEGREE <b>MD</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |   |   |   |   |   |  | 22c. DATE SIGNED<br><b>10/28/68</b>                   |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>ALFRED R. LAPIN, MD</b>  |  | 22e. ADDRESS<br><b>CLINTON, MD</b>  |   |   |   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>10-31-68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b>   |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington D. C.</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>Wilhelm Funeral Home 4308 Suitland Rd. S. E.</b>   |  |   |   | ADDRESS<br><b>4308 Suitland Rd. S. E.</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>NOV 4 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b> |   |  |

MEDICAL CERTIFICATION

VGW

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-6. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill out pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## Item 2a Film 07 12/3/68 kk DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14854

|   |  |  |  |  |  |  |  |   |   |  |
|---|--|--|--|--|--|--|--|---|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>Patrick M. Curley</b>  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>10</b> Day <b>13</b> Year <b>1968</b> |  |  | 2b. HOUR <b>M</b>  |  |   |   |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>                         |  | 5. DATE OF BIRTH <b>13 Nov. 1889</b>   |  | 6. AGE (In years birth day) <b>78</b> YRS.   |  | 7c. DATE PRONOUNCED DEAD<br>Month <b>Oct</b> Day <b>13</b> Year <b>1968</b> |   |  |
| 7a. BIRTHPLACE (State or foreign country) <b>W. Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b> |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Pr. Geo.</b>   |  |   | 2d. HOUR <b>M</b>   |  |
| 10. CITY OR TOWN OF DEATH <b>Riverdale</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Iceland Memorial</b>       |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Ret. Clerk</b>  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Off</b>      |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>STATE Md.</b>  |  |  | 13b. COUNTY <b>Pr. Geo.</b>  |  | 13c. CITY OR TOWN <b>Cheverly</b>                            |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER <b>2813 Laurel Ave.</b>              |  |
| 14. FATHER'S NAME<br>First <b>John</b> Middle <b>Curley</b> Last <b>Curley</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Catherine</b> Middle <b>Daughety</b> Last <b>Daughety</b>             |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>W YES</b>  |  |   | 16b. SOCIAL SECURITY NO. <b>WW XI One</b>                   |  |
| 17. INFORMANT <b>Mrs Thomas Vacchi</b>  |  |  | ADDRESS <b>Same as # 13 (Daughter)</b>   |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASHO-</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>4200</b> |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4722</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>CAA - 87925</b>   |  |  |  |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                               |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |   |   |  |
| ACTUAL SIGNATURE <b>John Kehoe</b>  |  |  | M.D. <b>JOHN KEHOE</b>   |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   | 22b. DATE SIGNED <b>10-13-68</b>                            |  |
| EXAMINER'S NAME (Type)  |  |  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |   |  |
|   |  |  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |   |  |
|   |  |  |  |  |  | ADDRESS (Street, city, town, or county)  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  |  | 23b. DATE <b>10/16/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt Carmel Cemetery</b> |  |  | 23d. LOCATION (City or Town) (County) (State) <b>Wood West Va</b>           |   |  |
| 24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>  |  |  | ADDRESS  |  |  | 25a. REC'D BY REGISTRAR <b>OCT 16 1968</b>   |  |   | 25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>           |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |   |  |  |                                   |   |  |
|--|--|--|--|---|---|--|--|-----------------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |  |  |                                   |   |  |
| 14846  |  |  |  |   | 14855   |  |  |                                   |   |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  |   | 2a. DATE OF DEATH   |  |  | 2b. HOUR                          |   |  |
| First Middle Last<br>Stacey O. Daigneault  |  |  |  |   | 10 Month 2 Day 68 Year  |  |  | 4 <sup>30</sup> P M               |   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |   |  | 6. AGE (In years last birthday)                                      |                                   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| Male   |  | White  |  | 7-4-98  |   |  | 70 YRS.  |                                   |   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |                                   |   |  |
| Vermont  |  | USA  |  |   |   | Prince Georges Md.   |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| Riverdale, Md.   |  | Leland Memorial  |  |   | Retired clerk   |  |  | Hotel                             |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER            |   |  |
| Md.  |  | Prince G.  |  | Hyatts.   |   | X  |  | 1508 Madison St.                  |   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |   |   |  |  |                                   |   |  |
| First Middle Last<br>Joseph Daigneault   |  | First Middle Last<br>Ruth Hubbard  |  |   |   |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address   |   |  |  |                                   |   |  |
| Yes, no, or unknown  |  | 579 01 6384A   |  | Zella C Daigneault Hyattsville, Md.   |   |  |  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |   |  |  |                                   |   |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |   |   |  |  |                                   |   |  |
| IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE   |  |  |  |   |   |  |  |                                   |   |  |
| 4129 DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC C.V DISEASE   |  |  |  |   |   |  |  |                                   |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UNKNOWN   |  |  |  |   |   |  |  |                                   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |   |  |  |                                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |   |  |  |                                   |   |  |
| 4221 PULM. EMPHYSEMA   |  |  |  |   |   |  |  |                                   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |                                   |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |  |  |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 27 SEP, 1968, to 2 OCT., 1968, that (I) (we) lost saw the deceased alive on 2 OCT. 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |  |                                   |   |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  |   |   |  |  |                                   |   |  |
| C.J. Houmann   |  | 2 OCT. 1968  |  |   |   |  |  |                                   |   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |   |   |  |  |                                   |   |  |
| C-J. HOUMANN M.D.  |  | RIVERDALE M.D.   |  |   |   |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)  |  |                                   |   |  |
| Burial   |  | 10/5/68  |  | Forest Lawn Cemetery  |   | Norfolk Norfolk Va.  |  |                                   |   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. REC'D BY REGISTRAR  |  |   | 25b. REGISTRAR'S SIGNATURE  |  |  |                                   |   |  |
| F. Gasch's Sons  |  | Hyattsville, Md  |  |   | DATE OCT 7 1968 J Charles Judge   |  |  |                                   |   |  |

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30M REV. 1-68

| 14847   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 14856  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
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| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| First Middle Last   |  |  |  |  |  |  |  |  |  | Month Day Year   |  |  |  |  |  |  |  |  |  | P.M.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Alvah Daniels   |  |  |  |  |  |  |  |  |  | October 1  |  |  |  |  |  |  |  |  |  | Year 68 9:30   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 3. SEX Female   |  |  |  |  |  |  |  |  |  | 4. RACE White  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH July 22, 1911   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday) 57 YRS.  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS               |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) Md.   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |  |  |  |  |  |  |  |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH Prince Georges Md.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH Cheverly  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges  |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of last year, if retired.) Housewife  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY None   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.   |  |  |  |  |  |  |  |  |  | 13b. COUNTY Balt.  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN Baltimore  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER 1823 Berrywood Rd. |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last Sewell Evans  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last Pearl Webster   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown NO  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. UNKNOWN   |  |  |  |  |  |  |  |  |  | 17. INFORMANT Charles G. Daniels (same as # 13)  |  |  |  |  |  |  |  |  |  | Address  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) 1621 Carcinoma of Lung.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |  |  |  |  |  |  | (b) DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | (c) DUE TO, OR AS A CONSEQUENCE OF Dysplastic Carcinoma.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION 163X   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from August 1966, to September 1968, that (I) (we) last saw the deceased alive on September 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Medical Examiner Notified & Approved |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE Jamshed Hamed MD   |  |  |  |  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED 10/2/68   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) JAMSHED HAMED.   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS 204-E 70TH Rd   |  |  |  |  |  |  |  |  |  | 22f. ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL  |  |  |  |  |  |  |  |  |  | 23b. DATE 10-4-68  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY ST. PAUL'S CEMETERY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) WENONA Som MD                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR Leroy Webster  |  |  |  |  |  |  |  |  |  | ADDRESS 2nd 21853  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR DATE OCT 7 1968  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE Charles Judge   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |

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1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                              |  |  |                                    |   |   |  |  |
|--|--|------------------------------|--|--|------------------------------------|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                              |  |  |                                    |   |   |  |  |
| CERTIFICATE OF DEATH   |  |                              |  |  |                                    |   |   |  |  |
| 1. DECEASED-NAME (Type or print)   |  |                              | First Middle Last  |  |                                    | 2a. DATE OF DEATH   |   | 2b. HOUR   |  |
| William Henry DeVaughn   |  |                              |  |  |                                    | Month Day Year  |   | 12:45 PM   |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH   |                                    | 6. AGE (In years last birthday)   |   | IF UNDER 1 YEAR MONTHS DAYS  |  |
| Male   |  | White                        |  | April 10, 1881   |                                    | 87 YRS.   |   |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |   |  |  |
| Maryland   |  | U. S. A.                     |  |  |                                    | Prince Georges  |   | Md.  |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Cheverly   |  |                              | Pr.Geo's Gen. Hosp:  |  |                                    | Tobacco Farmer  |   | Own Farm   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                              | 13b. COUNTY  |  |                                    | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| Md.  |  |                              | Pr/Geo's   |  |                                    | Upper Marlboro  |   | Largo Rd.  |  |
| 14. FATHER'S NAME  |  |                              | 15. MOTHER'S MAIDEN NAME   |  |                                    |   |   |  |  |
| First Middle Last  |  |                              | First Middle Last  |  |                                    |   |   |  |  |
| Joseph -- DeVaughn   |  |                              | May -- Tayman  |  |                                    |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |                              | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT   |   |  |  |
| No   |  |                              | ---  |  |                                    | Margaret Pushee-4801 Old Largo Rd., Upper Marlboro, Md.                                 |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                              |  |  |                                    |   |   |  |  |
| PART I. DEATH CAUSED BY:   |  |                              |  |  |                                    |   |   |  |  |
| IMMEDIATE CAUSE (a) Cerebral Thrombosis  |  |                              |  |  |                                    |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Sclerosis  |  |                              |  |  |                                    |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |                              |  |  |                                    |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                              |  |  |                                    |   |   |  |  |
| 332X   |  |                              |  |  |                                    |   |   |  |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug, 1968, to Oct 27, 1968, that (I) (we) last saw the deceased alive on Oct 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |                                    |   |   |  |  |
| 22b. SIGNATURE Robert B. Sasscer, M.D.   |  |                              |  |  |                                    | 22c. DATE SIGNED Oct. 27, 1968  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type) Robert B. Sasscer, M.D.   |  |                              |  |  |                                    | 22e. ADDRESS Upper Marlboro, Md. 20870  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION (City or Town) (County) (State) |  |  |
| Burial   |  |                              | 10/30/68   |  | Ft. Lincoln Cem:                   |   | Bladensburg, P. Geo., Md.                     |  |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |                              |  |  |                                    | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |  |
| Ritchie Bros. Upper Marlboro, Md.  |  |                              |  |  |                                    | NOV 12 1968   |   | Charles Judge  |  |



Dr. Kehoe, coroner, consulted & has released Perez's body - Certificate to be signed by Dr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1 (5-4)  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br><u>DiCarlo,</u>   |  | Middle<br><u>Joseph</u>   |  | Last<br><u>A.</u>   |  | 2a. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>3</u> Year <u>1968</u> |  | 2b. HOUR<br><u>1:50am</u>                          |
| 3. SEX<br><u>Male</u>  |  | 4. RACE<br><u>Caucasion</u>  |  | 5. DATE OF BIRTH<br><u>6-26-24</u>  |  | 6. AGE (In years<br>lost birthday)<br><u>44</u> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <u>  </u> DAYS <u>  </u>                   |  | IF UNDER 24 HRS.<br>HOURS <u>  </u> MIN. <u>  </u> |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><u>D.C.</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><u>Prince George's</u> Md.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Riverdale</u>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><u>Eugene Leland Memorial</u> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><u>Foreman PEPCO</u>  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><u>Maryland</u>  |  | 13b. COUNTY<br><u>Prince George</u>  |  | 13c. CITY OR TOWN<br><u>Park College</u>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><u>5807 Bucknell Terrace</u>               |  |  |
| 14. FATHER'S NAME<br>First <u>James</u> Middle <u>I.</u> Last <u>DiCarlo</u>   |  | 15. MOTHER'S MAIDEN NAME<br>First <u>Francis</u> Middle <u>Giuffrida</u> Last <u>  </u>                          |  |   |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)  |  | 17. INFORMANT<br>Address<br><u>Frances DiCarlo (spouse) &amp; Medical Records</u>   |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u><br><u>4309</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) <u>Rupture Intracranial Aneurysm</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>  </u><br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><u>330x</u>  |  |  |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>19</u><br>P.M. <u>  </u>        |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                  |  | 21f. LOCATION Street or R.F.D. No. <u>  </u> City or Town <u>  </u> County <u>  </u> State <u>  </u>  |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 29, 1968</u> , to <u>Oct 2, 1968</u> , that (I) (we) lost<br>saw the deceased alive on <u>Oct 2, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Baltazar E. Perez, M.D.</u>   |  | 22c. DATE SIGNED<br><u>Oct 3/68</u>  |  | 22d. ADDRESS<br><u>10305 Folk St. Silver Spring MD</u>  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE<br><u>Oct 5, 1968</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery</u>  |  | 23d. LOCATION (City or Town) <u>Suitland Pro Geo</u> (County) <u>  </u> (State) <u>Md.</u>      |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>F. Gasch's Sons</u>   |  | ADDRESS<br><u>Hyattsville, Md.</u>   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>OCT 7 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Jones</u>   |  |  |  |  |

14888

14888

Subscribed by Mr. J. C. ...  
... of ...

Oct 2 1888

Oct 2/88

James H. ...

1888 Folio 21

1888



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV.

| <div> <div>5</div> <div>1</div> <div>14850</div> </div> <div> <div>14850</div> <div>1</div> </div>   |  |  |  |   |  |   |   |                                   |  |
|--|--|--|--|---|--|---|---|-----------------------------------|--|
| <div> <div>1</div> <div>2</div> </div>   |  |  |  |   |  |   |   |                                   |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  |   | First Middle Last  |   | 2a. DATE OF DEATH   |                                   | 2b. HOUR                                     |
| MALCOLM  |  |  |  |   | DISNEY   |   | Oct. 22, 1968   |                                   | M  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |   | 6. AGE (In years lost birthday)   |                                   | IF UNDER 1 YEAR MONTHS DAYS                  |
| Male   |  | White  |  | Jan 15, 1989  |  |   | 79 YRS.   |                                   | IF UNDER 24 HRS. HOURS MIN                   |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |   |                                   |  |
| Highland, Md.  |  | U.S.   |  |   |  | Prince George Md.   |   |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Riverdale, Md.   |  |  | Leland Mem.  |   |  | Garage owner  |   | Garage                            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |
| Highland, Md.  |  |  | Howard   |   |  |   |   |                                   |  |
| 14. FATHER'S NAME First Middle Last  |  |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last   |   |   |                                   |  |
| Charles T. Disney  |  |  |  |   | Margaret E. Wilson   |   |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address  |   |   |                                   |  |
| no   |  |  |  |   | Roland L. Disney Highland, Md.   |   |   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |   |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |   |  |   |   |                                   |  |
| IMMEDIATE CAUSE (a) myocardial infarction  |  |  |  |   |  |   |   |                                   | 2 hours                                      |
| DUE TO, OR AS A CONSEQUENCE OF (b) coronary occlusion  |  |  |  |   |  |   |   |                                   | 4 hours                                      |
| DUE TO, OR AS A CONSEQUENCE OF (c) generalized arteriosclerosis  |  |  |  |   |  |   |   |                                   | years  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |   |                                   |  |
| 4201 none  |  |  |  |   |  |   |   |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |                                   |  |
|  |  |  |  |   |  |   |   |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |                                   |  |
|  |  |  |  |   |  |   |   |                                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |   | County                            | State  |
|  |  |  |  |   |  |   |   |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from May, 1964, to Oct 22, 1968, that (I) (we) last saw the deceased alive on Oct 22, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |                                   |  |
| 22b. SIGNATURE   |  |  |  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   |   | 22c. DATE SIGNED                  |  |
| John R. Buell  |  |  |  |   |  |   |   | Oct 22, 1968                      |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | JOHN R. BUELL, M.D., 8116 GORMAN AVENUE LAUREL, MARYLAND                     |  |   | 22e. ADDRESS   |   |   |                                   |  |
|  |  |  |  |   |  |   |   |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |   |                                   |  |
| Burial   |  | Oct. 23, 1968  |  | Mt. Zion  |  | Highland, Md.   |   |                                   |  |
| 24. FUNERAL DIRECTOR, ADDRESS  |  |  |  |   | 25a. REC'D BY REGISTRAR DATE   |   | 25b. REGISTRAR'S SIGNATURE  |                                   |  |
| Donaldson Funeral Home Laurel, Md.   |  |  |  |   | OCT 28 1968  |   | f Charles Judge   |                                   |  |

14888

DEPARTMENT OF HEALTH

14888

U.S. DEPARTMENT OF HEALTH  
BUREAU OF VETERINARY MEDICINE  
WASHINGTON, D.C.

14888

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14851

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14860

|  |                         |   |   |   |   |
|--|-------------------------|---|---|---|---|
| 1. DECEASED-NAME<br>(Type or Print)<br>First Middle Last<br><b>Mary Dittman</b>  |                         |   | 2a. DATE KNOWN <input type="checkbox"/> Month Day Year<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> <b>10-3-68</b> 194: <b>00am</b> M |   |   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>7-29-1922</b>  | 6. AGE (In years<br>last birthday)<br><b>46</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   | IF UNDER 24 HRS.  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Va</b>  |                         |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |                         |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Prince George Hospital</b>  |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Housewife</b>  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Maryland</b>  |                         |   | 13b. CITY OR TOWN<br><b>Prince George's Maryland Park</b>   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 14. FATHER'S NAME<br>First Middle Last<br><b>William M Sudduth</b>   |                         |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Rose A Dowson</b>   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>no</b>   |                         |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>Roy N Curtis Maryland Park, Md.</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Rupture of spleen</b><br><b>571.8</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Splenomegaly</b><br>(b) <b>From portal hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Cirrhosis of liver</b><br>(c)<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.                |                         |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>5810</b>   |                         |   |   |   |   |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                            |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |   |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <b>19</b>                |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                             |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |   |   |   |   |
| ACTUAL<br>SIGNATURE<br><b>John Kehoe</b><br>EXAMINER'S<br>NAME (Type)<br><b>John Kehoe MD Riverdale, Md.</b>   |                         | 22b. DATE SIGNED<br><b>10-3-68</b>  |   | 22c. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town, or county) |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>Oct 7, 1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington National</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons Hyattsville, Md.</b>  |                         | 23d. LOCATION (City or Town) (County) (State)<br><b>Suitland Pro Geo Md.</b>    |   | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 8 1968</b>   |   |
|  |                         |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                              |  |   |                                    |   |   |  |   |
|---|--|------------------------------|--|---|------------------------------------|---|---|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                              |  |   |                                    |   |   |  |   |
| CERTIFICATE OF DEATH  |  |                              |  |   |                                    |   |   |  |   |
| 1. DECEASED-NAME<br>(Type or print)   |  |                              | First Middle Last  |   |                                    | 2a. DATE OF DEATH   |   |  | 2b. HOUR  |
| Mary A. Donath  |  |                              |  |   |                                    | Month Day Year<br>October 5, 1968   |   |  | 7:10 AM   |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH  |                                    |   | 6. AGE (In years last birthday)               |  | 7. UNDER 1 YEAR<br>MONTHS DAYS  |
| Female  |  | White                        |  | 7/6/81  |                                    |   | 87 YRS.                                       |  | 8. UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |   |  |   |
| Wash DC.  |  | USA                          |  |   |                                    | Prince George's Md.   |   |  |   |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| Cheverly  |  |                              | Prince George's Gen.   |   |                                    | Retired   |   |  | GPO   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |                              | 13b. COUNTY  |   |                                    | 13c. CITY OR TOWN   |   |  | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Maryland  |  |                              | Pr. Geo.   |   |                                    | Landover Hills  |   |  | 13e. STREET AND NUMBER<br>4204 72nd Avenue  |
| 14. FATHER'S NAME   |  |                              | 15. MOTHER'S MAIDEN NAME   |   |                                    |   |   |  |   |
| First Middle Last<br>John R Hutchison   |  |                              | First Middle Last<br>Mary Shuchan  |   |                                    |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  |                              | 16b. SOCIAL SECURITY NO.   |   |                                    | 17. INFORMANT   |   |  | Address   |
| No  |  |                              | None   |   |                                    | 217 525386 Ann Wetzstein  |   |  | same  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                              |  |   |                                    |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarct</u>   |  |                              |  |   |                                    |   |   |  | 15 hr   |
| 4109 DUE TO, OR AS A CONSEQUENCE OF   |  |                              |  |   |                                    |   |   |  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |                              |  |   |                                    |   |   |  |   |
| (b) <u>advanced arteriosclerotic and coronary disease</u>   |  |                              |  |   |                                    |   |   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                              |  |   |                                    |   |   |  |   |
| (c)   |  |                              |  |   |                                    |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                              |  |   |                                    |   |   |  |   |
| 4201 <u>Cancer of the throat.</u>   |  |                              |  |   |                                    |   |   |  |   |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |                                    | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |
|   |  |                              |  |   |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |                              | 21b. TIME OF INJURY  |   |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |
|   |  |                              | HOUR A.M. Month Day Year<br>P.M. 19  |   |                                    |   |   |  |   |
| 21d. INJURY OCCURRED  |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |                                    | 21f. LOCATION   |   |  |   |
| White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |                              |  |   |                                    | Street or R.F.D. No. City or Town County State  |   |  |   |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Oct. 1, 1968</u> , to <u>October 5, 1968</u> , that (I) (we) last saw the deceased alive on <u>October 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |   |                                    |   |   |  |   |
| 22b. SIGNATURE  |  |                              |  |   |                                    | DEGREE  |   | 22c. DATE SIGNED   |   |
| <u>Phil Lilly</u>   |  |                              |  |   |                                    | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 10.5.68.   |   |
| 22d. PHYSICIAN'S NAME (Type)  |  |                              |  |   |                                    | 22e. ADDRESS  |   |  |   |
| J.P. Lilly M.D.   |  |                              |  |   |                                    | 4410 74th Ave. Landover Hills, Md.  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION (City or Town) (County) (State) |  |   |
| Burial  |  |                              | 10/8/1968  |   | Glenwood Cemetery                  |   | Washington DC.                                |  |   |
| 24. FUNERAL DIRECTOR  |  |                              |  |   |                                    | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |   |
| Wally's funeral home  |  |                              |  |   |                                    | OCT 11 1968   |   | Charles Judge  |   |

18841

RECEIVED

(M)

(1)

18841



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14853 CERTIFICATE OF DEATH 14862

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY Prince George's MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE DISTRICT of COLUMBIA b. COUNTY                        |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE MD.   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.   |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CARROLL MANOR 4922 LA SALLE RD.   |  |   |  | d. STREET ADDRESS 2222 EYE ST. N.W.   |  |  |   |
| 3. NAME OF DECEASED<br>(Type or print) ALMA M. DORSEY  |  |   |  | 4. DATE OF DEATH<br>Month Day Year Oct 1 1968   |  |  |   |
| 5. SEX F   |  | 6. COLOR OR RACE W  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH 3-28-1885                                   |   |
| 9. AGE (In years last birthday) 83 yrs.  |  | IF UNDER 1 YEAR Months Days   |  | IF UNDER 24 HRS. Hours Min.   |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales lady   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE   |  | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND |   |
| 12. CITIZEN OF WHAT COUNTRY? US.   |  |   |  |   |  |  |   |
| 13. FATHER'S NAME GEORGE R. BREWER   |  |   |  | 14. MOTHER'S MAIDEN NAME JULIA M. WATHEN  |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No   |  |   |  | 16. SOCIAL SECURITY NO. 579-10-12225  |  | 17. INFORMANT MARGARET M. DORSEY 2 A & C, d. c. ABOVE        |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive Heart Failure<br>4120 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic and Hypertensive Heart Disease<br>DUE TO (c) Arteriosclerosis, general<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 443X Post-status: multiple pulmonary emboli |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>Years<br>Years<br>Years |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |  |   |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. 19   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                         |   |
| 21. I certify that (I) (this hospital) attended the deceased from April 17, 1967, to Oct 1, 1968, that (I) (we) last saw the deceased alive on Dec 30, 1968, and that death occurred at 9:50 PM, from the causes and on the date stated above.   |  |   |  |   |  |  |   |
| 22a. SIGNATURE John F. Brennan, Jr.  |  |   |  | 22b. DATE SIGNED Oct 1, 1968  |  |  |   |
| 22c. PHYSICIAN'S NAME (Type) JOHN F. BRENNAN, JR.  |  |   |  | 22d. ADDRESS 3344 RUNNYMEADE PL. N.W., WASHINGTON, DC.  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL   |  | 23b. DATE THEREOF 4 Oct. 1968   |  | 23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY  |  | 23d. LOCATION (City, town or county) (State) WASHINGTON, DC. |   |
| 24. FUNERAL DIRECTOR R. WARDI FUNERAL HOME, Inc. 7400 GEORGIA AVE. N.W.  |  |   |  | 25a. REC'D BY REGISTRAR OCT 3 1968  |  | 25b. REGISTRAR'S SIGNATURE Charles Judge                     |   |

MEDICAL CERTIFICATION

502

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |   |  |   |   |  |   |   |   |  |  |
|---|--|---|--|---|---|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(Type or print) <b>ROBERT E. DOVE</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>OCT</b> Day <b>7</b> Year <b>1968</b>                                    |   |   | 2b. HOUR<br><b>1:30</b> P. M.  |   |   |   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>W</b>                           |  | 5. DATE OF BIRTH<br><b>19 OCT. 1889</b>   |   | 6. AGE (In years<br>last birthday)<br><b>78</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                               |   | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>PR. GEORGE'S</b> Md.  |   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>HYATTSVILLE</b>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>3911 QUEENSBURY</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) <b>PLUMBING</b> |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>MD.</b>   |  |   | 13b. COUNTY <b>PR. GEO.</b>  |   | 13c. CITY OR TOWN<br><b>HYATTSVILLE</b>                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>3911 QUEENSBURY RD</b> |  |  |
| 14. FATHER'S NAME<br>First <b>ROBERT</b> Middle <b>DOVE</b> Last <b>DOVE</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>LOUISA</b> Middle <b>FOUTH</b> Last <b>FOUTH</b>                  |   |   |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)  |  |   | 16b. SOCIAL SECURITY NO.<br><b>578-38-1168</b>   |   | 17. INFORMANT<br>Address <b>WIFE - IVA C. ABOVE</b>     |  |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary emboli</b><br><b>4519</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) <b>Hypertensive</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |   |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>Family</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>464x Arteriosclerosis heart disease</b>   |  |   |  |   |   |  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                      |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                            |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                        |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1958</b> , 19____, to <b>1968</b> , 19____, that (I) (we) last<br>saw the deceased alive on <b>Oct 5, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. <b>DR. KEHOE NOTIFIED</b>            |  |   |  |   |   |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>L. Levitsky</b>  |  |   | 22c. PHYSICIAN'S<br>NAME (Type) <b>L. LEVITSKY</b>   |   |   | 22d. ADDRESS<br><b>MT. RAINIER MD</b>  |   | 22e. DATE SIGNED<br><b>10/7/68</b>                                      |   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify) <b>BURIAL</b>  |  |   | 23b. DATE<br><b>10/10/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL</b> |  | 23d. LOCATION (City or Town) (County) (State)<br><b>SUITLAND MD.</b>                            |   |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>F. GASCH'S SONS - Hyattsville, Md.</b>   |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 11 1968</b>   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |   |   |  |  |

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE SIGNED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE SIGNED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH.

# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |         |                              |  |  |                                    |   |   |   |   |          |      |
|--|---------|------------------------------|--|--|------------------------------------|---|---|---|---|----------|------|
| 1. DECEASED-NAME<br>(Type or Print)  |         |                              | First  | Middle   | Last                               | 2a. DATE KNOWN OF DEATH   |   |   | <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year | 2b. HOUR |      |
| Rebecca Ethel Dowell   |         |                              |  |  |                                    | 10-8-68   |   |   | 1911  | 10pm     |      |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR  |                                    | IF UNDER 24 HRS.  |   | 2c. DATE PRONOUNCED DEAD                      |   | 2d. HOUR |      |
| Female   | Negro   | 31 June 1906                 | 62 YRS.  | MONTHS   | DAYS                               | HOURS   | MIN.  | Month 10 Day 8 Year 68                        | 19  | 11:58am  |      |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |   |   |   |          |      |
|  |         | U.S.A.                       |  |  |                                    | Prince George's Md.   |   |   |   |          |      |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |          |      |
| Cheverly   |         |                              | Prince George Hospital   |  |                                    | None  |   |   |   |          |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER  |          |      |
| Maryland   |         |                              | Prince George's  |  | Croom                              |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |   | Box 3333, Mt. Calvert Rd.   |          |      |
| 14. FATHER'S NAME  |         |                              | First  | Middle   | Last                               | 15. MOTHER'S MAIDEN NAME  |   |   | First   | Middle   | Last |
| James Sims   |         |                              |  |  |                                    | Laurie Diggs  |   |   |   |          |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                              | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT   |   |   | ADDRESS   |          |      |
| No   |         |                              | None   |  |                                    | Regina Washington   |   |   | SARAH'S 13E.  |          |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Heart failure<br>4120<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>(c)   |         |                              |  |  |                                    |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>minutes<br>over 14yrs.                    |          |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>443X Diabetes - known over 14 yrs.  |         |                              |  |  |                                    |   |   |   |   |          |      |
| 19a. DATE OF OPERATION   |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |                                    | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |   |          |      |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                              | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                 |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |          |      |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |          |      |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |  |                                    |   |   |   |   |          |      |
| ACTUAL SIGNATURE   |         |                              | EXAMINER'S NAME (Type)   |  |                                    | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   |   | 22b. DATE SIGNED  |          |      |
| John Kehoe MD  |         |                              | Riverdale, Md.   |  |                                    | ADDRESS (Street, city, town, or county)   |   |   | 10-9-68   |          |      |
| 23a. BURIAL CREMATION REMOVAL (Specify)  |         |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   |   | 23d. LOCATION (City or Town) (County) (State) |   |          |      |
| 10-12-68   |         |                              | 31. Marys  |  | Croom Md                           |   |   |   |   |          |      |
| 24. FUNERAL DIRECTOR   |         |                              | ADDRESS  |  |                                    | 25a. REC'D BY REGISTRAR   |   |   | 25b. REGISTRAR'S SIGNATURE  |          |      |
| H.S. Washington + Sons   |         |                              | 4925 Deane Ave NE  |  |                                    | OCT 17 1968   |   |   | J Charles Judge   |          |      |

MEDICAL CERTIFICATION

2024

928 14 130



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in lines 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |  |  |  |                   |  |   |   |  |
|--|---------|--|--|--|-------------------|--|---|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |  |  |  |                   |  |   |   |  |
| 1. DECEASED-NAME (Type or Print)   |         |  | First Middle Last  |  |                   | 2a. DATE KNOWN OF DEATH  |   |   | 2b. HOUR                                     |
| Cecil M Downs  |         |  |  |  |                   | Month Day Year   |   |   | 10-20-68 19 8:45am                           |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (in years last birthday)  | IF UNDER 1 YEAR  |                   | IF UNDER 24 HRS.   |   | 2c. DATE PRONOUNCED DEAD                |  |
| Male   | White   | 4-17-1887  | 81 YRS.  | MONTHS   | DAYS              | HOURS  | MIN.  | Month Day Year                          | 10 20 68 19 9:02am M                         |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. COUNTY OF DEATH   |   |   |  |
| ILLINOIS   |         | U.S.   |  |  |                   | Prince George's Md.  |   |   |  |
| 10. CITY OR TOWN OF DEATH  |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |   |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Cheverly   |         |  | Prince George Hospital   |  |                   | CIVIL SERVICE  |   |   | U.S. Govt                                    |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |  | 13b. COUNTY  |  | 13c. CITY OR TOWN |  | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET AND NUMBER                       |
| Maryland   |         |  | Prince George's  |  | Bowie             |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 12414 Sandle Lane                            |
| 14. FATHER'S NAME First Middle Last  |         |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |                   |  |   |   |  |
| WILLIAM A. DOWNS   |         |  | EDITH CHESTER  |  |                   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT     |  | ADDRESS   |   |  |
| NO.  |         |  | 302.011626   |  | AUGUST P. BOLTZ   |  | SAME AS #13   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |  |                   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:   |         |  |  |  |                   |  |   |   | minutes                                      |
| IMMEDIATE CAUSE (a) Heart failure  |         |  |  |  |                   |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF Hypertensive arteriosclerotic heart disease   |         |  |  |  |                   |  |   |   | over 2 yrs.                                  |
| (b)  |         |  |  |  |                   |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |  |                   |  |   |   |  |
| (c)  |         |  |  |  |                   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |         |  |  |  |                   |  |   |   |  |
| 443X   |         |  |  |  |                   |  |   |   |  |
| 19a. DATE OF OPERATION   |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |                   |  | 20. AUTOPSY?  |   |  |
|  |         |  |  |  |                   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>  |         | 21b. TIME OF INJURY Month, Day, Year   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                   |  |   |   |  |
| CAUSE OF DEATH   |         | P.M. 19  |  |  |                   |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No.   |                   | City or Town   |   | County                                  | State  |
|  |         |  |  |  |                   |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |  |  |  |                   |  |   |   |  |
| ACTUAL SIGNATURE   |         |  | M.D.   |  |                   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | 22b. DATE SIGNED                        |  |
| EXAMINER'S NAME (Type)   |         |  |  |  |                   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                    |   | 10-21-68                                |  |
| John Kehoe MD  |         |  | Riverdale, Md.   |  |                   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                            |   | ADDRESS (Street, city, town, or county) |  |
|  |         |  |  |  |                   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                   | 23d. LOCATION (City or Town) (County) (State)  |   |   |  |
| ENTOMBMENT   |         | OCT 24, 1968   |  | MEMORIAL PARK  |                   | DAYTON, OHIO   |   |   |  |
| 24. FUNERAL DIRECTOR   |         | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |                   | 25b. REGISTRAR'S SIGNATURE   |   |   |  |
| W.W. CHAMBERS CO.  |         | RIVERDALE, MARYLAND  |  | OCT 30 1968  |                   | J. Charles Judge   |   |   |  |

14825

DEATH OF JOHN H. HARRIS, JR.

14825

14825

14825

14825

14825

OCT 30 1959

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14857

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14866

|   |                         |  |   |  |  |  |  |  |
|---|-------------------------|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(Type or Print) <b>Guy H Duckett</b>  |                         |  | 20. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 10-10-68 1968 10-10-68 1968 10-10-68 1968   |  |  | 2b. HOUR 50am  |  |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Negro</b> | 5. DATE OF BIRTH<br><b>12-9-1904</b>   | 6. AGE (In years last birthday)<br><b>63</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  | IF UNDER 24 HRS.<br>HOURS<br>MIN.                        | 2c. DATE PRONOUNCED DEAD<br>Month <b>10</b> Day <b>10</b> Year <b>68</b> 1968 7:11am                           |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince George Hospital</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Truck Driver</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Commercial Furniture Co.</b>                               |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before)<br><b>Maryland</b>  |                         |  | 13b. COUNTY<br><b>Prince George's Seat Pleasant</b>   |  | 13c. CITY OR TOWN<br><b>Seat Pleasant</b>                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           | 13e. STREET AND NUMBER<br><b>7205 F Street</b>                       |  |
| 14. FATHER'S NAME<br><b>Unknown</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br><b>Jane</b>   |  |  | 16. UNKNOWN  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   |                         |  | 16b. SOCIAL SECURITY NO.<br><b>577-10-6306</b>  |  | 17. INFORMANT<br><b>Elsie Duckett Pleasant, Md.</b>      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Coronary artery occlusion</b><br>(b) <b>From atherosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                        |                         |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>minutes</b><br><b>unknown</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4201</b>  |                         |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. <b>19</b>          |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   | 21f. LOCATION Street or R.F.D. No.   |  | City or Town   |  | County State   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>John Kehoe MD</b>  |                         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  | 22b. DATE SIGNED<br><b>10-11-68</b>  |  |  |
| EXAMINER'S NAME (Type)<br><b>John Kehoe MD Riverdale, Md.</b>   |                         |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                         |  | 23b. DATE<br><b>10-14-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lincoln Mem</b> |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Suitland Md.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Rollins 4339-Hunt PK NE</b>  |                         |  | 25a. REC'D BY REGISTRAR<br>DATE <b>Oct 14 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James Judge</b>         |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4 1  
14858  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14867

|  |  |  |   |  |
|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Virginia R. Duval</b>  |  | 2a. DATE OF DEATH<br>Month <b>Oct</b> Day <b>29</b> Year <b>1968</b>                 |   | 2b. HOUR<br><b>6 P/M</b>                             |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br><b>9-8-1884</b>  |   | 6. AGE (In years<br>last birthday)<br><b>84</b> YRS. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Washington</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. COUNTY OF DEATH<br><b>Prince George's</b>   |  | Md.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Prince Geo. Gen'l Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>housewife</b>  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                 |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Prince George's Seat Pleasant</b>  | 13c. CITY OR TOWN<br><b>Seat Pleasant</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET AND NUMBER<br><b>6815 Eads Street</b>    |
| 14. FATHER'S NAME First Middle Last<br><b>Joseph Palmer</b>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary Steele</b>                     |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>unknown</b>   | 17. INFORMANT<br><b>Nelson Duval</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b><br><b>4379</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) <b>Cerebral arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Generalized arteriosclerosis</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>6 days</b>                     |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>331X</b> <b>Pneumonia left lower lobe</b>  |  |  |   |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                      | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |   |  |
| 22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>January 1968</b> , to <b>10-29</b> , 19 <b>68</b> , that (I) <del>(we)</del> last<br>saw the deceased alive on <b>10-29</b> , 19 <b>68</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the<br>causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.                      |  |  |   |  |
| 22b. SIGNATURE<br><b>Peter Duus, M.D.</b>  |  | 22c. DATE SIGNED<br><b>Oct. 29, 1968</b>   |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>Peter Duus, M. D.</b>  |  | 22e. ADDRESS<br><b>6056 Central Ave., Capitol Hgts, Md. 20027</b>                    |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>11-1-68</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Congressional</b>                           | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington, D. C.</b>   |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Wilhelm Funeral Home 4308 Suitland Rd. S. E.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>NOV 6 1968</b>                                    | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

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14887

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14859

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14868

|   |         |   |          |   |   |   |  |
|---|---------|---|----------|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First   | Middle   | Last  | 2a. DATE KNOWN<br>OF<br>DEATH MATED <input checked="" type="checkbox"/> 10-7-68 14:43pm M |   | 2b. HOUR   |
| Hazel   |         | LOVELESS  |          | EARLY   |   |   |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  |          | 6. AGE (in years<br>last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year 10 7 68 19 5:20pm M |
| Female  | White   | 2-3-1910  |          | 58 YRS.   |   |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Prince George's Md.   |  |
| MARYLAND  |         | U.S.A.  |          |   |   |   |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)                         |          | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |
| Cheverly  |         | Prince George Hospital  |          | ASST. CASHIER   |   | BANK  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |         | 13b. CITY OR TOWN   |          | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET AND NUMBER  |  |
| Maryland  |         | Prince George's Brandywine  |          |   |   | Rt4, Box 142A   |  |
| 14. FATHER'S NAME   |         | First   | Middle   | Last  | 15. MOTHER'S MAIDEN NAME  |   | First Middle Last  |
| SAMUEL  |         | O.  | LOVELESS |   | MARY  |   | E. BADEN   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)                                       |          | 17. INFORMANT   |   | ADDRESS   |  |
| NO  |         | 214-36-3047   |          | ROLAND EARLY, BRANDYWINE, MD.   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Laceration of brain<br>8199<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. }<br>DUE TO, OR AS A CONSEQUENCE OF Compound skull fracture of skull<br>(b) From trauma - auto accident<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                               |         |   |          |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |   |          |   |   |   |  |
| 8254  |         |   |          |   |   |   |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |          |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>4:42pm 10-7-1968                                   |          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Involved in auto accident.   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)<br>Rt. 301 and Rt. 381, |          | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>Prince George County, Maryland  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |   |          |   |   |   |  |
| ACTUAL<br>SIGNATURE   |         | EXAMINER'S<br>NAME (Type)   |          | John Kehoe MD Riverdale, Md.  |   | 22b. DATE SIGNED<br>10-8-68   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |         | 23b. DATE   |          | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)                                       |  |
| BURIAL  |         | 10-11-68  |          | FT. LINCOLN Cem.  |   | BLADENSBURG, MD.  |  |
| 24. FUNERAL DIRECTOR  |         | ADDRESS   |          | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE  |  |
| HUNT FUNERAL HOME, WALDORF, MD.   |         |   |          | OCT 14 1968   |   | gcharles Judge  |  |

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |   |   |  |   |  |   |   |  |
|---|--|---|---|---|--|---|--|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Clara M Erhart</i>   |  |   | 2a. DATE OF DEATH<br>Month <i>Oct.</i> Day <i>10</i> Year <i>68</i>   |   |  | 2b. HOUR<br><i>9:18 P.</i>  |  |   |   |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>Caucasian</i>                   |   | 5. DATE OF BIRTH<br><i>Aug. 16, 1882</i>  |  | 6. AGE (In years last birthday)<br><i>86</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.     |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>New York</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i> |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Prince George's</i> Md.  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Cheverly</i>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Prince Geo. Gen'l Hospital</i> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>housewife</i> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Maryland</i>  |  |   | 13b. COUNTY<br><i>Prince George's</i>   |   |  | 13c. CITY OR TOWN<br><i>Mt. Rainier</i>   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><i>4234 34th Street</i>   |  |   | 14. FATHER'S NAME<br>First <i>Fred</i> Middle <i>Kitner</i> Last <i>Riley</i>                                     |   |  | 15. MOTHER'S MAIDEN NAME<br>First <i>Margaret</i> Middle <i>Riley</i> Last <i>Riley</i>                     |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)<br><i>None</i>   |  |   | 16b. SOCIAL SECURITY NO.<br><i>216 22 0716</i>  |   |  | 17. INFORMANT<br><i>Dorothy Carr</i>  |  |   | Address<br><i>4234 34th St Mt. Rainier</i>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pt. Cerebral Vascular Accident</i><br><i>4360</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Severe, Generalized Arterio-sclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>12 hrs.</i><br><i>5 yrs.</i> |  |   |   |   |  |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>331X Hypertensive Cardio-Vascular Disease</i>  |  |   |   |   |  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>   |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                             |  |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |  |
| 22a. I certify that (I) <del>XXXXXX</del> attended the deceased from <i>Sept 5, 1968</i> , to <i>Oct. 10, 1968</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>Oct. 10</i> 1968, and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.   |  |   |   |   |  |   |  |   |   |  |
| 22b. SIGNATURE<br><i>Charles C. Hageage</i> M.D.<br>DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |   |   |   |  |   |  |   | 22c. DATE SIGNED<br><i>Oct. 10, 1968</i>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>Charles C. Hageage, M. D.</i>  |  |   | 22e. ADDRESS<br><i>3308 Perry St. Mt. Rainier, Md.</i>  |   |  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  |   | 23b. DATE<br><i>10/14/1968</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Fort Lincoln Cemetery Colmar Manor, Md.</i> |   |  | 23d. LOCATION (City or Town) (County) (State) |   |  |
| 24. FUNERAL DIRECTOR<br><i>Nalley's</i>   |  |   | ADDRESS<br><i>Funeral Home Mt. Rainier, Md.</i>   |   |  | 25a. REC'D BY REGISTRAR<br>DATE <i>OCT 15 1968</i>  |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.)

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |  |   |  |   |  |   |
|---|--|---|---|---|--|---|--|---|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |  |   |  |   |  |   |
| CERTIFICATE OF DEATH  |  |   |   |   |  |   |  |   |  |   |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First   |   | Middle   |   | Last   |   | 2a. DATE OF DEATH<br>Month Day Year        |   |
| Josephine   |  |   | Farrell   |   | Oct.   |   | 31,  |   | 1968                                       |   |
| 3. SEX  |  | 4. RACE   |   | 5. DATE OF BIRTH  |  |   | 6. AGE (In years<br>last birthday)   |   | 2b. HOUR                                   |   |
| Female  |  | Caucasian   |   | Nov. 17, 1902   |  |   | 65   |   | 1:30AM                                     |   |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |   |  |   |
| Wash DC   |  | USA   |   |   |  | Prince George's Md.   |  |   |  |   |
| 10. CITY OR TOWN OF DEATH   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)                                      |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY              |  |   |
| Cheverly  |  |   | Prince Geo. Gen'l Hospital  |   |  | housewife   |  | home  |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER                     |   |
| Maryland  |  |   | Prince George's   |   | Beltsville   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                             |   | 11353 Edmonston Avenue                     |   |
| 14. FATHER'S NAME   |  |   | First   |   | Middle   |   | Last   |   | 15. MOTHER'S MAIDEN NAME First Middle Last |   |
| John Hunt   |  |   |   |   |  |   |  |   | Margaret Farrell                           |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)   |  |   | 16b. SOCIAL SECURITY NO.  |   |  | 17. INFORMANT   |  |   | Address                                    |   |
| no  |  |   |   |   |  | Barbara Prince  |  |   | Beltsville Md                              |   |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |   |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:  |  |   |   |   |  |   |  |   |  |   |
| IMMEDIATE CAUSE (a) <u>HYPOGLYCEMIC SHOCK</u>   |  |   |   |   |  |   |  |   |  |   |
| 2500 DUE TO, OR AS A CONSEQUENCE OF   |  |   |   |   |  |   |  |   |  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u>  |  |   |   |   |  |   |  |   |  |   |
| (b) <u>DIABETES MELLITUS: TREATED WITH INSULIN</u>  |  |   |   |   |  |   |  |   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |   |  |   |  |   |  |   |
| (c)   |  |   |   |   |  |   |  |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |   |  |   |  |   |  |   |
| (A) HYPERTENSION: (B) OBESITY.  |  |   |   |   |  |   |  |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? Yes          |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |   |  |   |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |   |
| 22a. I certify that (I) <del>(the doctor)</del> attended the deceased from <u>Sept. 7</u> , 19 <u>68</u> , to <u>Oct. 31</u> , 19 <u>68</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>Oct. 31</u> , 19 <u>68</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death. |  |   |   |   |  |   |  |   |  |   |
| 22b. SIGNATURE<br><u>Charles C. Hageage M.D.</u> DEGREE   |  |   |   |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>11/1/68</u>                |  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Charles C. Hageage, M. D.</u>  |  |   |   |   |  | 22e. ADDRESS<br><u>3308 Perry Street, Mt. Rainier, Md.</u>  |  |   |  |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE<br><u>Nov 4, 1968</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Ignace</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Chesman Manor PG Md</u>   |  |   |  |   |
| 24. FUNERAL DIRECTOR<br><u>Donaldson J.H.</u> ADDRESS<br><u>Lawet. Md.</u>  |  |   |   |   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>NOV 8 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judd</u> |  |   |

10221



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |  |  |
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| Item 7a Film G406 11/14/68   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  | 14862  |  |
| 1. DECEASED NAME (Type or print)   |  | First Middle Last  |  | 2a. DATE OF DEATH  |  |
| Harry J. Feaster   |  |  |  | 10 Month 24 Day 68 Year  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |
| Male   |  | White  |  | 10-17-04   |  |
| 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |  |
| 66 64 YRS.   |  | MONTHS DAYS  |  | HOURS MIN  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Wash. D.C.   |  | USA  |  | 9. COUNTY OF DEATH   |  |
|  |  |  |  | Prince George Md.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |
| College Park   |  | 3423 Metzertott Rd.,   |  | Painter  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  |
| Maryland   |  | Pr. Geo.   |  | College Park   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown   |  |
| Bentley Feaster  |  | Ruth Whiting   |  | (If yes give war or dates of service)  |  |
| 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address  |  |
| 072 14 5957  |  | Patients former record in Medical Record                                     |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2041 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocardial Failure (c) Chronic Hypertensive Disease |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2040  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1968, to 1968, that (I) (we) last saw the deceased alive on Oct 14 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                         |  | 22b. SIGNATURE OF PHYSICIAN  |  | 22c. DATE SIGNED   |  |
| 22b. PHYSICIAN'S NAME (Type)   |  | 22c. ADDRESS   |  | 22c. DATE SIGNED   |  |
| W. Etienne, M.D.   |  | College Park Md.   |  | 10/24/68   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial   |  | Oct 26, 1968   |  | Ft Lincoln Cemetery  |  |
| 23d. LOCATION (City or Town) (County) (State)  |  | 23d. LOCATION (City or Town) (County) (State)                                |  | 23d. LOCATION (City or Town) (County) (State)  |  |
| Colmar Manor Pro Geo Md.   |  | Colmar Manor Pro Geo Md.   |  | Colmar Manor Pro Geo Md.   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |
| F. Gasch's Sons Hyattsville, Md.   |  | DATE OCT 28 1968   |  | Charles Judge  |  |

Dear Mr. [illegible]  
 I have just the [illegible]  
 [illegible] [illegible]  
 [illegible] [illegible]

*[Handwritten signature]*

W. J. L. L.

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Item 6 Film 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

## CERTIFICATE OF DEATH

14872

|  |  |           |   |                  |  |  |                                    |  |   |  |  |                        |                                  |  |
|--|--|-----------|---|------------------|--|--|------------------------------------|--|---|--|--|------------------------|----------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |           | First Middle Last   |                  |  | 2a. DATE OF DEATH  |                                    |  | 2b. HOUR  |  |  |                        |                                  |  |
| Charles W. Ferguson  |  |           |   |                  |  | Oct. 8, 1968   |                                    |  | 8 A.M.  |  |  |                        |                                  |  |
| 3. SEX   |  | 4. RACE   |   | 5. DATE OF BIRTH |  |  | 6. AGE (In years<br>last birthday) |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.   |                        |                                  |  |
| Male   |  | Caucasian |   | 1-24-87          |  |  | 74 81 YRS.                         |  | MONTHS DAYS   |  | HOURS MIN.   |                        |                                  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  |           | 7b. CITIZEN OF WHAT COUNTRY?  |                  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    |  | 9. COUNTY OF DEATH  |  |  |                        |                                  |  |
| West Virginia  |  |           | U.S.A.  |                  |  |  |                                    |  | Prince George's   |  |  | Md.                    |                                  |  |
| 10. CITY OR TOWN OF DEATH  |  |           | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |                  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)   |                                    |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |  |  |                        |                                  |  |
| Cheverly   |  |           | Prince Geo. Gen'l Hospital  |                  |  | Builder  |                                    |  | Self  |  |  |                        |                                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  |           | 13b. COUNTY   |                  |  | 13c. CITY OR TOWN  |                                    |  | 13d. INSIDE CITY LIMITS?  |  |  | 13e. STREET AND NUMBER |                                  |  |
| Maryland   |  |           | Prince George's   |                  |  | Beltsville   |                                    |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     |  |  | 11719 Erack Road       |                                  |  |
| 14. FATHER'S NAME  |  |           | 15. MOTHER'S MAIDEN NAME  |                  |  |  |                                    |  |   |  |  |                        |                                  |  |
| Charles Walter Ferguson  |  |           | Janette Taylor  |                  |  |  |                                    |  |   |  |  |                        |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  |           | 16b. SOCIAL SECURITY NO.  |                  |  | 17. INFORMANT  |                                    |  |   |  |  |                        |                                  |  |
| No   |  |           | None  |                  |  | 579167329J Margaret Moran  |                                    |  | 11719 Erack Road  |  |  | Beltsville, Maryland   |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |           |   |                  |  |  |                                    |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                |                        |                                  |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ruptured artiosclerotic aneurysm of the aortic</u><br><u>441.0</u> DUE TO, OR AS A CONSEQUENCE OF <u>arch with massive hemorrhage into</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>the left lung.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis.</u> |  |           |   |                  |  |  |                                    |  |   |  |  |                        |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>451X</u> <u>Chronic passive congestion of liver and abscessed spleen.</u>   |  |           |   |                  |  |  |                                    |  |   |  |  |                        |                                  |  |
| 19a. DATE OF OPERATION   |  |           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |                  |  | 20a. AUTOPSY?  |                                    |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |  |                        |                                  |  |
|  |  |           |   |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                    |  | Yes   |  |  |                        |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |           | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                                    |  |   |  |  |                        |                                  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |           | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                                    |  |   |  |  |                        |                                  |  |
| 22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>8-1-</u> , 19 <u>68</u> , to <u>Oct. 8,</u> 19 <u>68</u> , that (I) <u>xxx</u> lost<br>saw the deceased alive on <u>Oct. 8</u> 19 <u>68</u> , and that in (my) <u>(xxx)</u> opinion death occurred on the date and hour and from the<br>causes stated above, (I) <u>(xxx)</u> (did) <u>xxxxx</u> view the body after death. |  |           |   |                  |  |  |                                    |  |   |  |  |                        |                                  |  |
| 22b. SIGNATURE<br><u>Oliver B. Bond</u>  |  |           |   |                  |  |  |                                    |  | DEGREE ATTENDING<br>PHYS. <input checked="" type="checkbox"/>           |  | MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |                        | 22c. DATE SIGNED<br>Oct. 8, 1968 |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Oliver Bond, M. D.  |  |           |   |                  |  |  |                                    |  | 22e. ADDRESS<br>6872 Riverdale Rd., Lanham, Md. 20801                   |  |  |                        |                                  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  |           | 23b. DATE   |                  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                    |  | 23d. LOCATION (City or Town) (County) (State)                           |  |  |                        |                                  |  |
| Burial   |  |           | 10/11/1968  |                  |  | Pt. Lincoln Cemetery   |                                    |  | Colmar Manor, Maryland  |  |  |                        |                                  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>Nalley's Funeral Home Mt. Rainier, Md.  |  |           |   |                  |  | 25a. REC'D BY REGISTRAR<br>DATE OCT 10 1968  |                                    |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                      |  |  |                        |                                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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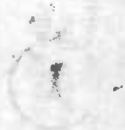
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |  |  |   |   |   |   |                              |   |
|--|---------|--|--|---|---|---|---|------------------------------|---|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |  |  |   |   |   |   |                              |   |
| 1. DECEASED-NAME<br>(Type or Print)  |         |  | First Middle Last  |   |   | 2a. DATE KNOWN OF DEATH   |   |                              | 2b. HOUR  |
| John Joseph Finegan  |         |  |  |   |   | Month Day Year  |   |                              | 10-29-68 19 3:30pm  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (In years lost birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS  |   | IF UNDER 24 HRS.<br>HOURS MIN.  |   | 2c. DATE PRONOUNCED DEAD     |   |
| Male   | White   | 7-8-1918   | 50 YRS.  |   |   |   |   | Month Day Year               |   |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   |                              |   |
| Pennsylvania   |         | USA  |  |   |   | Prince George's Md.   |   |                              |   |
| 10. CITY OR TOWN OF DEATH  |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   |                              | 12b. KIND OF BUSINESS OR INDUSTRY                                     |
| Cheverly   |         |  | Prince George Hospital   |   |   | Investigator - US Army  |   |                              | Government  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?  |                              | 13e. STREET AND NUMBER  |
| Maryland   |         |  | Prince George's  |   | Bowie   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                            |                              | 12319 Manship Lane  |
| 14. FATHER'S NAME<br>First Middle Last   |         |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                |   |   |   |   |                              |   |
| Thomas Finagan   |         |  | Catherine UNK.   |   |   | unk   |   |                              |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |         |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS   |   |   |                              |   |
| Yes  |         |  | WW II  |   | 181-09-8608 Hosp. Records   |   |   |                              |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Liver failure fr. Fatty metamorphosis of liver</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>and Acute and chronic pancreatitis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                           |         |  |  |   |   |   |   |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>days<br>days and yrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>5810  |         |  |  |   |   |   |   |                              |   |
| 19a. DATE OF OPERATION   |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |         |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                 |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |   |                              |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |   |                              |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |  |  |   |   |   |   |                              |   |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)   |         |  | John Kehoe MD Riverdale, Md.   |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   | 22b. DATE SIGNED<br>10-30-68 |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)   |   |                              |   |
| Burial   |         | 11-2-68  |  | Holy Sepulchre Cemetery   |   | Wyndmoor, Pennsylvania  |   |                              |   |
| 24. FUNERAL DIRECTOR   |         |  |  | ADDRESS<br>Washington, D.C.   |   | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |   |
| Rinaldi Funeral Home, 7400 Georgia Ave, NW   |         |  |  | DATE  |   | NOV 1 1968  |   | J Charles Judge              |   |

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

14863

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14874

|   |  |                           |  |   |  |   |   |   |  |  |                                |  |  |
|---|--|---------------------------|--|---|--|---|---|---|--|--|--------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>MARY R FORD</b>  |  |                           | 2a. DATE OF DEATH<br><b>10</b> Month <b>26</b> Day <b>1968</b> Year          |   |  | 2b. HOUR<br><b>8 P M</b>  |   |   |  |  |                                |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>COLORED</b> |  | 5. DATE OF BIRTH<br><b>5/14/194</b>   |  |   | 6. AGE (In years last birthday)<br><b>74</b> YRS. |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |                           | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>                                    |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. COUNTY OF DEATH<br><b>PRINCE GEORGES</b> Md.                            |  |                                |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CLINTON</b>   |  |                           |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>CLINTON COMMUNITY HOSP</b> |  |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>None</b>                  |  |  |                                | 12b. KIND OF BUSINESS OR INDUSTRY                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD</b>  |  |                           |  | 13b. COUNTY<br><b>CHARLES</b>   |  |   |   | 13c. CITY OR TOWN<br><b>Indian Head</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                | 13e. STREET AND NUMBER<br><b>105 Woodland Rd</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Unknown</b>   |  |                           |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary Bean</b>  |  |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b> |  |  |                                |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>218-07-6647D</b>   |  |                           |  | 17. INFORMANT<br><b>Mary R. Bean-Daughter</b>   |  |   |   | Address <b>105 Woodland Rd Indian Head, Md</b>  |  |  |                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>arteriosclerotic Cardiovascular Disease</b> |  |                           |  |   |  |   |   |   |  |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4330</b> <b>Coronary</b>   |  |                           |  |   |  |   |   |   |  |  |                                |  |  |
| 19a. DATE OF OPERATION<br><b>10/26/1968</b>   |  |                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Coronary</b>          |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?       |  |                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |                           | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br><b>19</b>                 |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |                                |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |                           | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/26/1968</b> , to <b>Death</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Oct 26</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |                           |  |   |  |   |   |   |  |  |                                |  |  |
| 22b. SIGNATURE<br><b>Robert W. Merkle</b> DOCTOR  |  |                           |  |   |  |   |   |   |  |  |                                | 22c. DATE SIGNED<br><b>10/26/1968</b>            |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>ROBERT W. MERKLE</b>   |  |                           |  |   |  |   |   |   |  |  |                                | 22e. ADDRESS<br><b>Clinton, Maryland</b>         |  |
| 23a. BURIAL, CREMATION, or other disposition<br><b>Burial</b>   |  |                           | 23b. DATE<br><b>10/30/1968</b>   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart Cemetery</b>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>La Plata, Maryland</b> |  |                                |  |  |
| 24. FUNERAL DIRECTOR<br><b>ARCHART FEMALE Home</b>  |  |                           |  |   |  | ADDRESS<br><b>LA PLATA, MD.</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE<br><b>NOV 4 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                   |                                |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|   |                              |   |   |   |   |   |                                |
|---|------------------------------|---|---|---|---|---|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George</b> <b>MARYLAND</b>   |                              |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b> |   |   |                                |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Accokeek</b>   |                              |   |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Accokeek</b>   |   |   |                                |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |                              |   |   | d. STREET ADDRESS<br><b>114 Accokeek Rd.</b>  |   |   |                                |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Leona</b> Middle <b>Laura</b> Last <b>Frazier</b>   |                              |   |   | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>6</b> Year <b>19 68</b>  |   |   |                                |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>C</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 23, 1905</b> |   | 9. AGE (In years last birthday)<br><b>63</b> yrs. | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Norfolk Co. Virginia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                |
| 13. FATHER'S NAME<br><b>James Y. Cuffee</b>   |                              |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary E. Faulk</b>  |   |   |                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>579-52-7865</b>   |   | 17. INFORMANT<br><b>Mrs. Celestine Baskerville</b>  |   | Address <b>114 Accokeek Rd. Accokeek, Md</b>  |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b><br><b>4360</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General Arteriosclerosis</b><br>DUE TO (c) <b>Hypertension</b> |                              |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hrs.</b><br><b>years</b><br><b>years</b>                |                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>331X</b>  |                              |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |   |   |                                |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>a.m.</b> <b>19</b> p.m.  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |                                |
| 21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>9-30</b> , 19 <b>68</b> to <b>10-4</b> , 19 <b>68</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>10-4</b> , 19 <b>68</b> , and that death occurred at <b>A</b> .M., from the causes and on the date stated above.   |                              |   |   |   |   |   |                                |
| 22a. SIGNATURE<br><b>Paul Chen</b>  |                              |   |   | 22b. DATE SIGNED<br><b>Oct 10, 1968</b>   |   | 22c. PHYSICIAN'S NAME (Type)<br><b>Paul Chen, M.D.</b>  |                                |
| 22d. ADDRESS<br><b>Accokeek, Maryland 20607</b>   |                              |   |   |   |   |   |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              | 23b. DATE THEREOF<br><b>Oct. 10, 1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Family Cemetery</b>  |   | 23d. LOCATION (City, town or county) (State)<br><b>Cheasapeake, Virginia</b>                      |                                |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert G. Mason Co. Inc. 2500 Nichols Ave</b>  |                              |   |   | 25a. REC'D BY REGISTRAR<br><b>OCT 10, 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |                                |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |                                   |  |  |
|--|--|--|--|--|--|---|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |                                   |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |                                   |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH   |  | 2b. HOUR                          |  |  |
| Benjamin F. Galloway Jr.   |  |  |  |  |  | Oct. Month 26, Day 1968 Year  |  | 8:15PM                            |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years lost birthday)   |  | IF UNDER 1 YEAR MONTHS DAYS       |  |  |
| Male   |  | Caucasian  |  | May 18, 1912   |  | 56 YRS.   |  |                                   |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| North Carolina   |  | U. S. A.   |  |  |  | Prince George's   |  | Miller Sales                      |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                                   |  |  |
| Cheverly   |  |  | Prince Geo. Gen'l Hospital   |  |  | Salesman  |  |                                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |  |
| Maryland   |  |  | Prince George's  |  | Hyattsville  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                   | 5800 15th Place                              |  |
| 14. FATHER'S NAME First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |   |  |                                   |  |  |
| Benjamin F. Galloway, Sr.  |  |  | Ella McFee   |  |  |   |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |   |  |                                   |  |  |
| No   |  |  |  |  | Jackson Funeral Home, Hendersonville N. C.   |   |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |                                   |  |  |
| IMMEDIATE CAUSE (a) <u>Hypertension</u>  |  |  |  |  |  |   |  |                                   |  |  |
| 1991 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |                                   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |   |  |                                   |  |  |
| (b) <u>METASTATIC CARCINOMA - LUNG. Primary - skin</u>   |  |  |  |  |  |   |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |                                   |  |  |
| (c) <u>Chronic Malnutrition</u>  |  |  |  |  |  |   |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |  |  |  |  |   |  |                                   |  |  |
| 1992   |  |  |  |  |  |   |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |  |  |
|  |  |  |  |  |  |   |  |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |                                   |  |  |
|  |  |  |  |  |  |   |  |                                   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |                                   |  |  |
|  |  |  |  |  |  |   |  |                                   |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>9/22/68</u> , 19 <u>68</u> , to <u>Oct. 26,</u> 19 <u>68</u> , that <del>we</del> (we) last saw the deceased alive on <u>Oct. 26,</u> 19 <u>68</u> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (we) <del>did not</del> view the body after death. |  |  |  |  |  |   |  |                                   |  |  |
| 22b. SIGNATURE <u>P. C. Xavier, M. D.</u>  |  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED   |                                   |  |  |
|  |  |  |  |  |  |   | Oct. 28, 1968  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  | 22e. ADDRESS   |   |  |                                   |  |  |
| P. C. Xavier, M. D.  |  |  |  |  | Prince Geo. Gen'l Hospital, Cheverly, Md.  |   |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |  |  |
| Burial   |  | Nov. 1, 1968   |  | Laurel Hill Cemetery   |  | Candler, North Carolina   |  |                                   |  |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |  |  | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |                                   |  |  |
| Howard H. Hubbard 4107 Wilkens Ave. Balto.   |  |  |  |  | OCT 29 1968  |   | <u>Charles Judge</u>   |                                   |  |  |

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| 14868  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201      |  |  |  |  |  |  |  |  |  | 14877  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
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| 1. DECEASED-NAME (Type or print)   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| First Middle Last  |  |  |  |  |  |  |  |  |  | Month Day Year   |  |  |  |  |  |  |  |  |  | M  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| MOLLY (NMN) GERUS  |  |  |  |  |  |  |  |  |  | Oct 14, 1968   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 3. SEX F   |  |  |  |  |  |  |  |  |  | 4. RACE W  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS               |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |
| April 22, 1892   |  |  |  |  |  |  |  |  |  | 16   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) UKRAINIA   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH PRINCE GEORGES. Md.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH BEAIR 7 BOWIE  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)     |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) HOUSEWORK   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.  |  |  |  |  |  |  |  |  |  | 13b. COUNTY PRGEO  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN BEMIA BOWIE  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER 12403 MADELEY LANE |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last LUCIUS   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last ANNA KURICTSA                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. 195-30-1572   |  |  |  |  |  |  |  |  |  | 17. INFORMANT MRS. JACK MERKLE   |  |  |  |  |  |  |  |  |  | Address 12403 MADELEY LANE   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1579 Metastatic cancer of liver |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of Pancreas                            |  |  |  |  |  |  |  |  |  | 4 months   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  | 157X   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                 |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19                                  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)     |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 6th, 1968, to Oct 14th, 1968, that (I) (we) last saw the deceased alive on Sept 16th, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE Leonard P. Appel M.D. DEGREE                                      |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED 10/14/68  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) LEONARD P. APPEL  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS 3231 Superior Lane, Bowie Md 20715                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  |  |  |  |  |  | 23b. DATE Oct. 18, 1968  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY SUTTON HILL CEMETERY  |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) WARREN Co. Penna.                              |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Laurel Funeral Home, Laurel, Md. 20810   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | DATE OCT 18 1968   |  |  |  |  |  |  |  |  |  | J. Charles Judge   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Pages 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <div> <p>14869</p> <p><b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b></p> </div> <div> <p>14878</p> </div> </div>   |         |   |   |   |                                   |  |   |  |  |   |
|---|---------|---|---|---|-----------------------------------|--|---|--|--|---|
| 1. DECEASED-NAME<br>(Type or Print)   |         |   | First Middle Last   |   |                                   | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED  |   |  | 2b. HOUR                               |   |
| Isador Ray Gibson   |         |   |   |   |                                   | 10-29-68   |   |  | 19 3:00am                              |   |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (In years<br>last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                                   | IF UNDER 24 HRS.<br>HOURS MIN.   |   | 2c. DATE PRONOUNCED DEAD   |  | 2d. HOUR  |
| Male  | White   | 12-21-1900  | 67 YRS.   |   |                                   |  |   | 10 29 68   |  | 19 3:07am                                       |
| 7a. BIRTHPLACE (State or foreign<br>country)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. COUNTY OF DEATH   |   |  |  |   |
| Va  |         | U S A   |   |   |                                   | Prince George's Md.  |   |  |  |   |
| 10. CITY OR TOWN OF DEATH   |         |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |                                   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |   |
| Cheverly  |         |   | Prince George Hospital  |   |                                   | Retired cabinet maker  |   |  | U S Govt                               |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |         |   | 13b. COUNTY   |   |                                   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                          |
| Maryland  |         |   | Prince George's   |   |                                   | Riverdale  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                             |  | 6319 61st. Avenue                               |
| 14. FATHER'S NAME   |         |   | 15. MOTHER'S MAIDEN NAME  |   |                                   | 17. INFORMANT ADDRESS  |   |  |  |   |
| First Middle Last<br>Samuel Gibson  |         |   | First Middle Last<br>Catherine B Warner   |   |                                   | L. May Gibson Riverdale, Md.   |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         |   | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)               |   |                                   | 17. INFORMANT ADDRESS  |   |  |  |   |
| no  |         |   | 578 05 3731A  |   |                                   | L. May Gibson Riverdale, Md.   |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebro vascular occlusion</u><br>433.9<br>DUE TO, OR AS A CONSEQUENCE OF <u>Generalized arteriosclerosis</u><br>over 3 yrs.<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____    |         |   |   |   |                                   |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br>332X  |         |   |   |   |                                   |  |   |  |  |   |
| 19a. DATE OF OPERATION  |         |   | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                            |   |                                   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19                       |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                   |  |   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |   | 21f. LOCATION Street or R.F.D. No.  |                                   | City or Town   |   | County   |  | State   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |   |   |   |                                   |  |   |  |  |   |
| ACTUAL<br>SIGNATURE   |         |   | M.D.  |   |                                   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |  | 22b. DATE SIGNED                       |   |
| EXAMINER'S<br>NAME (Type)   |         |   | John Kehoe MD Riverdale, Md.  |   |                                   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |  | 10-29-68                               |   |
|   |         |   |   |   |                                   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                |   |  | ADDRESS(Street, city, town, or county) |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |         |   | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CRYPTORY |  | 23d. LOCATION (City or Town) (County) (State)                                       |  |  |   |
| Burial  |         |   | Oct 31, 1968  |   | George Washington                 |  | Hyattsville Pro Geo Md.   |  |  |   |
| 24. FUNERAL DIRECTOR  |         |   | ADDRESS   |   |                                   | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |  |   |
| F. Gasch's Sons   |         |   | Hyattsville, Md.  |   |                                   | NOV 1 1968   |   | Charles Judge  |  |   |

85841

2325

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14870

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14879

|   |                         |   |  |   |                  |  |   |   |  |
|---|-------------------------|---|--|---|------------------|--|---|---|--|
| 1. DECEASED-NAME<br>(Type or Print)<br>First Middle Last<br><b>Darlene M. Goldsborough</b>  |                         |   | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/> 10-27-68 194:15amM |   |                  | 2b. HOUR   |   |   |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>4-11-1964</b>          | 6. AGE (In years last birthday)<br><b>4</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>10 27 68 194:15am M</b>   |   |   | 2d. HOUR   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |                         |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince George Hospital</b>                            |   |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>None</b>                                 |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                           |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death)<br><b>Maryland</b>  |                         |   | 13b. CITY OR TOWN<br><b>Prince George's Seat Pleasant</b>  |   |                  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |   | 13e. STREET AND NUMBER<br><b>708 Greig Street</b>                          |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Joseph L. Goldsborough</b>   |                         |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Willie V. Unangst</b>  |   |                  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b><br>(If yes give war or dates of service)                |   |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>None</b>   |                         |   | 17. INFORMANT<br><b>Joseph L. Goldsborough</b>   |   |                  | ADDRESS<br><b>4608 Lewis Ave. Suitland Md.</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septicemia</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Pseudomonas infection</b><br>(b) <b>From burns of 70% of body surface</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |                         |   |  |   |                  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><b>9160</b>  |                         |   |  |   |                  |  |   |   |  |
| 19a. DATE OF OPERATION  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |                  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                         |   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br><b>12:35pm 9-23-1968</b>  |   |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Burned when clothing caught fire from stove.</b> |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |                         |   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Home</b>  |   |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>same as #13</b>   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |   |  |   |                  |  |   |   |  |
| ACTUAL SIGNATURE<br><b>John Kehoe</b>   |                         |   | M.D.   |   |                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |   | 22b. DATE SIGNED<br><b>10-28-68</b>  |
| EXAMINER'S NAME (Type)<br><b>John Kehoe MD</b>  |                         |   | Riversdale, Md.  |   |                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |   | ADDRESS (Street, city, town, or county)<br><b>Suitland, Maryland</b>       |
| 23a. BURIAL-CREMATATION, REMOVAL (Specify)<br><b>Burial</b>   |                         |   | 23b. DATE<br><b>10-30-68</b>   |   |                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington National</b>   |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Suitland, Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>W. W. Chambers Co. 517-11, D.C.</b>  |                         |   |  |   |                  | 25a. REC'D BY REGISTRAR<br><b>NOV 6 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b> |  |



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NOV 8 1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14880

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 1. DECEASED-NAME (Type or print) <b>CHARLOTTE A. GORMAN</b>   |  | 2a. DATE OF DEATH Month <b>OCT</b> Day <b>5</b> Year <b>1968</b>   |  | 2b. HOUR <b>2P.</b> M  |   |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH <b>Jul 8, 1935</b>  |   |
| 6. AGE (In years last birthday) <b>33</b> YRS.  |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>  |  | IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>   |   |
| 7a. BIRTHPLACE (State or foreign country) <b>WASHINGTON, DC</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. COUNTY OF DEATH <b>PRINCE GEORGES</b> Md.  |  | 10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>PRINCE GEORGES</b>   |   |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>  |   |
| 13b. COUNTY <b>P.G.</b>   |  | 13c. CITY OR TOWN <b>BOWIE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 13e. STREET AND NUMBER <b>2602 KINDERBROOK</b>  |  | 14. FATHER'S NAME First <b>HOWARD</b> Middle <b>STODGNILL</b> Last <b></b>   |  | 15. MOTHER'S MAIDEN NAME First <b>DAISY</b> Middle <b>FEELEY</b> Last <b></b>  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>  |  | 17. INFORMANT <b>ROBERT J. GORMAN</b> Address <b>SAME AS #13</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>LUNG CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 YEAR</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>163X NONE</b>  |  |  |  |  |   |
| 19a. DATE OF OPERATION <b>OCT 1967</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA LUNG</b>   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |   |
| 21b. TIME OF INJURY HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  |   |
| 21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>  |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT</b> , 19 <b>67</b> , to <b>OCT 5</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>OCT 3</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE <b>Norman K Bohrer MD</b> DEGREE <b></b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  | 22c. DATE SIGNED <b>OCT 5, 1968</b>  |  |  |   |
| 22d. PHYSICIAN'S NAME (Type) <b>NORMAN K. BOHRER MD.</b>  |  | 22e. ADDRESS <b>BOWIE MARYLAND</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  | 23b. DATE <b>10-8-1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>GATE 4 HEAVEN CEM</b>  |   |
| 23d. LOCATION (City or Town) <b>WHEATON</b> (County) <b>MARYLAND</b> (State) <b></b>  |  | 24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO. RIVERDALE, MARYLAND</b> ADDRESS <b></b>  |  |  |   |
| 25a. REC'D BY REGISTRAR <b>OCT 8 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>   |  |  |   |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14872

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14881

|   |                         |  |   |   |   |   |  |  |
|---|-------------------------|--|---|---|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>Thomas Francis Gray</b>  |                         |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>10</b> Day <b>23</b> Year <b>1968</b>    |   |   | 2b. HOUR <b>1:30pm</b>  |  |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Negro</b> | 5. DATE OF BIRTH<br><b>1-15-1898</b>   | 6. AGE (in years last birthday)<br><b>70</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>                    | 2c. DATE PRONOUNCED DEAD<br>Month <b>10</b> Day <b>23</b> Year <b>1968</b>                      |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>P. Geo. Md.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince George Hospital</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)         |  | 12b. KIND OF BUSINESS OR INDUSTRY                  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |                         |  | 13b. COUNTY<br><b>Prince George's</b>   |   | 13c. CITY OR TOWN<br><b>Brandywine</b>                              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br><b>Box 135</b> |  |
| 14. FATHER'S NAME<br><b>Isiah</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br><b>Frances Hall</b>   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |                         |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS<br><b>Vincent Gray - Box 135 Aquasco, Md.</b> |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>unknown</b> |                         |  |   |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><b>4200</b>  |                         |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b> P.M.             |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  |  | County State                                       |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>                       |                         |  |   |   |   |   |  |  |
| ACTUAL SIGNATURE<br><b>John Kehoe</b>   |                         |  | M.D.<br><b>John Kehoe MD</b>  |   |   | 22b. DATE SIGNED<br><b>10-24-68</b>   |  |  |
| EXAMINER'S NAME (Type)<br><b>John Kehoe MD</b>  |                         |  | ADDRESS<br><b>Riverdale, Md.</b>  |   |   | 22c. DATE SIGNED<br><b>10-24-68</b>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                         | 23b. DATE<br><b>10-26-68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>House of Prayer # 2 cem.</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Brandywine, P. Geo. Md.</b>                 |  |  |
| 24. FUNERAL DIRECTOR<br><b>Martell Adams</b>  |                         |  |   | ADDRESS<br><b>Aquasco, Md.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>OCT 30 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MAYLAND STATE DEPARTMENT OF HEALTH   |  |                              |  |  |   |   |   |  |  |  |
|--|--|------------------------------|--|--|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                              |  |  |   |   |   |  |  |  |
| 14873  |  |                              |  |  | 14882   |   |   |  |  |  |
| 1. DECEASED-NAME (Type or print)   |  |                              |  |  | 2a. DATE OF DEATH   |   |   |  |  |  |
| Theresa P. Griffith  |  |                              |  |  | Month 10 Day 26 Year 68 230 M   |   |   |  |  |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH   |   | 6. AGE (In years lost birthday)   |   | 7. IF UNDER 1 YEAR MONTHS DAYS                                       |  |  |
| Female   |  | Negro                        |  | 3-22-1889  |   | 79 YRS.   |   | IF UNDER 24 HRS. HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   |  |  |  |
| Baltimore, Md.   |  | U.S.A.                       |  |  |   | Prince George's Md.   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| Upper Marlboro   |  |                              | -  |  |   | School Teacher  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER                       |  |
| Md.  |  |                              | P. Geo.  |  | Upper Marlboro  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | Box 3250                                     |  |
| 14. FATHER'S NAME First Middle Last  |  |                              | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |   |   |   |  |  |  |
| Edward Pyle  |  |                              | Sarah Ferguson   |  |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)   |  |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address   |   |   |  |  |  |
|  |  |                              |  |  | Wm. L. Griffith - same as above   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                              |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction   |  |                              |  |  |   |   |   |  |  |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF  |  |                              |  |  |   |   |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Cardiovascular Disease  |  |                              |  |  |   |   |   |  | Spt  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |                              |  |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                              |  |  |   |   |   |  |  |  |
| 4201   |  |                              |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |   |  |  |  |
|  |  |                              |  |  |   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from May, 1963, to Oct., 1968, that (I) (we) last saw the deceased alive on 10/18/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE   |  |                              |  |  | DEGREE  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED                             |  |
| A. Clark Holmes M.D.   |  |                              |  |  |   |   |   |  | 10/26/68                                     |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |                              |  |  | 22e. ADDRESS  |   |   |  |  |  |
| A. Clark Holmes M.D.   |  |                              |  |  | 14806 Pratt Street Upper Marlboro, Md.  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |
| Burial   |  |                              | 10-30-68   |  | Mt. Carmel Ch. Cem.   |   | Upper Marlboro, P. Geo. Md.   |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |                              |  |  | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Martell Adams Aquasco, Md.   |  |                              |  |  | DATE NOV 1 1968   |   | J. Charles Judge  |  |  |  |

15883

RECEIVED

15883

W. J. WILSON  
15883

15883



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>14876</div> <div> <div>1</div> <div> <div>14883</div> <div> <div>1</div> <div> <div>14883</div> </div> </div> </div> </div>  |  |  |  |  |        |   |           |  |   |  |                                |  |
|---|--|--|--|--|--------|---|-----------|--|---|--|--------------------------------|--|
| 1. DECEASED NAME<br>(Type or print)   |  |  | First  |  | Middle |   | Last      |  | 2a. DATE OF DEATH<br>Month Day Year   |  | 2b. HOUR<br>M                  |  |
| Laura   |  |  |  |  |        |   | Griffiths |  | 10 20 68  |  |                                |  |
| 3. SEX  |  |  | 4. RACE  |  |        | 5. DATE OF BIRTH  |           |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS |  |
| Female  |  |  | W  |  |        | 10-31-89  |           |  | 78 YRS.   |  |                                |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |           |  | 9. COUNTY OF DEATH<br>Prince George Md.   |  |                                |  |
| PA  |  |  | USA  |  |        |   |           |  |   |  |                                |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |           |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                |  |
| Forestville   |  |  | Regent Nursing Home<br>7420 Marlowe Pike                                     |  |        | Housewife   |           |  | HOME  |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  |        | 13c. CITY OR TOWN   |           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER         |  |
| MD  |  |  | PG   |  |        | Marlow Hts.   |           |  |   |  | 5935 23 Place                  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |        |   |           |  |   |  |                                |  |
| First Middle Last   |  |  | First Middle Last  |  |        |   |           |  |   |  |                                |  |
| WALTER BROWNLEE   |  |  | UNKNOWN  |  |        |   |           |  |   |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  |        | 17. INFORMANT   |           |  | Address   |  |                                |  |
| UNKNOWN   |  |  | UNKNOWN  |  |        | Laura Comerford, same as #13, (Daughter)  |           |  |   |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis?</u><br>4109<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |        |   |           |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4201  |  |  |  |  |        |   |           |  |   |  |                                |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |           |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |                                |  |
|   |  |  |  |  |        |   |           |  |   |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |           |  |   |  |                                |  |
|   |  |  |  |  |        |   |           |  |   |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |           |  |   |  |                                |  |
|   |  |  |  |  |        |   |           |  |   |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.<br><u>See Reverse side</u>                 |  |  |  |  |        |   |           |  |   |  |                                |  |
| 22b. SIGNATURE<br>J. H. Thibodeau M.D.  |  |  | 22c. DATE SIGNED<br>10-20-68   |  |        | 22d. PHYSICIAN'S NAME (Type)<br>J. H. Thibodeau   |           |  | 22e. ADDRESS<br>3112 AIA Ave. S.E.  |  |                                |  |
|   |  |  |  |  |        |   |           |  |   |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE  |  |        | 23c. NAME OF CEMETERY OR CREMATORY  |           |  | 23d. LOCATION (City or Town) (County) (State)   |  |                                |  |
| BURIAL  |  |  | 10-25-68   |  |        | UNION CEMETERY  |           |  | PECKVILLE, PENNA.   |  |                                |  |
| 24. FUNERAL DIRECTOR Wilhelm Funeral Home<br>4308 Suitland Rd. SE, Suitland, Maryland   |  |  |  |  |        | 25a. REC'D BY REGISTRAR<br>DATE OCT 28 1968   |           |  | 25b. REGISTRAR'S SIGNATURE<br>J. Charles Judge  |  |                                |  |

20 Oct 68 - New signed certificate in absence  
of Dr. Humphreys - Previous history of  
bilateral cataracts heart disease and endocarditis  
myocarditis - Probable cause death  
coronary thrombosis - Arteriosclerosis  
J. H. Thacker 9/20

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

| 14875  |  |                  |   |  |  |   |  |   |   | 14884  |  |  |  |   |  |  |                       |  |  |
|--|--|------------------|---|--|--|---|--|---|---|--|--|--|--|---|--|--|-----------------------|--|--|
| 1. DECEASED-NAME (Type or Print)<br>First Middle Last<br>Walter D Haight   |  |                  |   |  |  |   |  |   |   | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br>10-3-68   |  |  |  |   | 2b. HOUR<br>19 4:30am                        |  |                       |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White |   | 5. DATE OF BIRTH<br>4-11-1899  |  | 6. AGE (In years last birthday)<br>69 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |   | IF UNDER 24 HRS<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>10 3 68 19 5:17am                      |  |   |  |  | 2d. HOUR<br>19 5:17am |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Washington, D.C.  |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                        |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH<br>Prince George's Md. |  |  |  |  |   |  |  |                       |  |  |
| 10. CITY OR TOWN OF DEATH<br>Cheverly  |  |                  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Prince George Hospital |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Sportswriter |   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Newspapers                                      |  |   |  |  |                       |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE<br>Maryland   |  |                  |   | 13b. COUNTY<br>Montgomery  |  |   |  | 13c. CITY OR TOWN<br>Silver Spring  |   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>2009 Osborne Drive  |  |  |                       |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Joe Haight   |  |                  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Phoebe Sneed |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>Yes   |  |   |   |  |  |  |  |   |  |  |                       |  |  |
| 16b. SOCIAL SECURITY NO.<br>N.W.I.   |  |                  | 17. INFORMANT<br>Florence E. Haight, Wife, same as # 13       |  |  |   |  |   |   |  |  |  |  | ADDRESS                                       |  |  |                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Coronary artery occlusion<br>4109<br>DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                  |   |  |  |   |  |   |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                       |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>4201  |  |                  |   |  |  |   |  |   |   |  |  |  |  |   |  |  |                       |  |  |
| 19a. DATE OF OPERATION   |  |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |                       |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  |                  |   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br>19   |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                         |   |  |  |  |  |   |  |  |                       |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |                  |   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                           |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |  |   |  |  |                       |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |                  |   |  |  |   |  |   |   |  |  |  |  |   |  |  |                       |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.  |  |                  |   |  |  |   |  |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  |  |  | 22b. DATE SIGNED<br>10-3-68                   |  |  |                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |                  |   | 23b. DATE<br>10-7-1968   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parklawn Cemetery   |  |   |   | 23d. LOCATION (City or Town) (County) (State)<br>Rockville, Montgomery, Md.  |  |  |  |   |  |  |                       |  |  |
| 24. FUNERAL DIRECTOR<br>Joseph Gawler's SONS, Inc., 5130 Wisc. Ave. N.W., Washington, D.C., 20016  |  |                  |   |  |  |   |  |   |   | 25a. REC'D BY REGISTRAR<br>OCT 7 1968  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>J Charles Judge |  |  |                       |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |  |  |   |  |   |  |
|---|--|---|---|---|--|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |  |  |   |  |   |  |
| 14876   |  |   |   |   | 14885  |  |   |  |   |  |
| 1. DECEASED-NAME (Type or print)<br>First Middle Last<br>Cicily Ball Haley  |  |   |   |   | 2a. DATE OF DEATH<br>Month Day Year<br>October 5 1968                  |  |   | 2b. HOUR<br>p<br>2:30  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White                              |   | 5. DATE OF BIRTH<br>July 4, 1878  |  | 6. AGE (In years last birthday)<br>90 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN      |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>England  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States |   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Prince George Md.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Hyattsville  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Sacred Heart Home |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME                            |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  |   | 13b. COUNTY<br>Anne Arundel   |   | 13c. CITY OR TOWN<br>Annapolis   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>96 Gloucester |  |
| 14. FATHER'S NAME<br>First Middle Last<br>George Ball   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Mary Taylor  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br>no   |  |   | 16b. SOCIAL SECURITY NO.<br>220-05-0496   |   | 17. INFORMANT<br>Sacred Heart Home<br>Address<br>Hyattsville, Maryland |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease &amp; Congestive heart failure</u><br>4129 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>5 years</u><br>Approximate interval between onset and death<br>3 days |  |   |   |   |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4200  |  |   |   |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                            |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)                      |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                      |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from May 24, 1968, to Oct 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Thomas F. Collins<br>DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |   |   |   |  | 22c. DATE SIGNED   |   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>THOMAS F. COLLINS   |  |   |   |   |  | 22e. ADDRESS<br>352 N. 101 NE  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |   | 23b. DATE<br>10-8-68  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington Natl.                  |  | 23d. LOCATION (City or Town) (County) (State)<br>Arlington Va.                                  |  |   |  |
| 24. FUNERAL DIRECTOR<br>John M. Loxton Annapolis, Md.   |  |   |   |   |  | 25a. REC'D BY REGISTRAR<br>DATE OCT 9 1968   |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                          |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |   |  |  |  |   |  |
|--|--|---|---|---|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |  |  |  |   |  |
| CERTIFICATE OF DEATH   |  |   |   |   |  |  |  |   |  |
| 1. DECEASED-NAME (Type or print)   |  |   | First <i>FANNIE</i> Middle <i>L</i> Last <i>HAMPTON</i>               |   |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
|  |  |   |   |   |  | Month <i>Oct</i> Day <i>25</i> Year <i>68</i>                        |  | M <i>6P</i>   |  |
| 3. SEX <i>F</i>  |  | 4. RACE <i>white</i>  |   | 5. DATE OF BIRTH <i>4/26/1896</i>   |  | 6. AGE (In years lost in YRS.) <i>72</i>                             |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <i>Prince Georges</i> Md.                         |  |   |  |
| 10. CITY OR TOWN OF DEATH <i>Lanham</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harper Nursing Home</i> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) STATE <i>Md</i>  |  | 13b. COUNTY <i>Prince Georges</i>   |   | 13d. CITY OR TOWN <i>Beltville</i>  |  | 13e. STREET AND NUMBER <i>11205 Charlotte La.</i>                    |  |   |  |
| 14. FATHER'S NAME First <i>Mike</i> Middle <i>scotte</i> Last <i>?</i>   |  |   | 15. MOTHER'S MAIDEN NAME First <i>?</i> Middle <i>?</i> Last <i>?</i> |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>   |  | 16b. SOCIAL SECURITY NO. <i>4339</i>  |   | 17. INFORMANT <i>Wm. Hampton Beltville, Md</i>  |  | 17a. ADDRESS <i>11205 Charlotte La. Beltville, Md</i>                |  | 17b. PHONE <i>937-7297</i>                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |   |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>  |  |   |   |   |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Arterio-sclerosis, adv</i>  |  |   |   |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arterio-sclerotic Heart Disease</i>  |  |   |   |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>332x</i>  |  |   |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 15 1968</i> to <i>Oct 25 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 25 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |  |  |   |  |
| 22b. SIGNATURE <i>W. L. Etienne</i>  |  | 22c. DATE SIGNED <i>10/25/68</i>  |   | 22d. PHYSICIAN'S NAME (Type) <i>W. L. ETIENNE</i>   |  | 22e. ADDRESS <i>College Park Md</i>                                  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE <i>10/27/68</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY <i>Family Cemetery</i>   |  | 23d. LOCATION (City or Town) (County) (State) <i>Manor Co Tenn</i>   |  |   |  |
| 24. FUNERAL DIRECTOR <i>Charles Jones</i>  |  | 24a. ADDRESS <i>Hyattsville Md</i>  |   | 25a. REC'D BY REGISTRAR <i>DA</i>   |  | 25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>                      |  |   |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pen in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |         |  |  |        |                                     |      |   |   | 14887            |  |   |  |                  |  |
|---|--|---------|--|--|--------|-------------------------------------|------|---|---|------------------|--|---|--|------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |         |  |  |        |                                     |      |   |   | 14887            |  |   |  |                  |  |
| 1. DECEASED-NAME<br>(Type or Print)   |  |         | First  |  | Middle |                                     | Last |   | 20. DATE KNOWN OF DEATH   |                  |  | 2b. HOUR                                      |  |                  |  |
| David R. Harris Sr.   |  |         |  |  |        |                                     |      |   | Month Day Year  |                  |  | 10-21-68 11:00am                              |  |                  |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH   |        | 6. AGE (in years last birthday)     |      | IF UNDER 1 YEAR   |   | IF UNDER 24 HRS. |  | 2c. DATE PRONOUNCED DEAD                      |  | 2d. HOUR         |  |
| Male  |  | White   |  | 10-15-1903   |        | 65 56 YRS.                          |      | MONTHS DAYS   |   | HOURS MIN.       |  | Month Day Year                                |  | 10 21 68 12:15pm |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  |        | 8. MARRIED                          |      |   | 9. COUNTY OF DEATH  |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY             |  |                  |  |
| N. Carolina   |  |         | U.S.A.   |  |        | NEVER MARRIED                       |      |   | Prince George's   |                  |  | Md.   |  |                  |  |
| 10. CITY OR TOWN OF DEATH   |  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |        |                                     |      |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY             |  |                  |  |
| Cheverly  |  |         | Prince George Hospital   |  |        |                                     |      |   | Equipment Operator  |                  |  |   |  |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)   |  |         | 13b. CITY OR TOWN  |  |        | 13c. INSIDE CITY LIMITS?            |      |   | 13e. STREET AND NUMBER  |                  |  |   |  |                  |  |
| Maryland  |  |         | Prince George's  |  |        | Mt. Rainier                         |      |   | YES NO  |                  |  | 4111 33rd. Street                             |  |                  |  |
| 14. FATHER'S NAME   |  |         | 15. MOTHER'S MAIDEN NAME   |  |        |                                     |      |   |   |                  |  |   |  |                  |  |
| Joseph Harris   |  |         | Della Henry  |  |        |                                     |      |   |   |                  |  |   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |         | 16b. SOCIAL SECURITY NO.   |  |        | 17. INFORMANT                       |      |   | ADDRESS   |                  |  |   |  |                  |  |
| NO  |  |         | 224-12-9528  |  |        | David R. Harris Jr. (above address) |      |   | (Son)   |                  |  |   |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |         |  |  |        |                                     |      |   |   |                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                  |  |
| PART I. DEATH WAS CAUSED BY:  |  |         |  |  |        |                                     |      |   |   |                  |  |   |  |                  |  |
| IMMEDIATE CAUSE (a) Massive bilateral pulmonary emboli  |  |         |  |  |        |                                     |      |   |   |                  |  |   |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |  |        |                                     |      |   |   |                  |  |   |  |                  |  |
| (b)   |  |         |  |  |        |                                     |      |   |   |                  |  |   |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |  |        |                                     |      |   |   |                  |  |   |  |                  |  |
| (c)   |  |         |  |  |        |                                     |      |   |   |                  |  |   |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |         |  |  |        |                                     |      |   |   |                  |  |   |  |                  |  |
| 465X  |  |         |  |  |        |                                     |      |   |   |                  |  |   |  |                  |  |
| 19a. DATE OF OPERATION  |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |        |                                     |      | 20. AUTOPSY?  |   |                  |  |   |  |                  |  |
|   |  |         |  |  |        |                                     |      | YES NO  |   |                  |  |   |  |                  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING   |  |         |  | 21b. TIME OF INJURY Month, Day, Year   |        |                                     |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |                  |  |   |  |                  |  |
| CAUSE OF DEATH  |  |         |  | HOUR A.M. P.M.   |        |                                     |      |   |   |                  |  |   |  |                  |  |
| 21d. INJURY OCCURRED  |  |         |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |        |                                     |      | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |                  |  |   |  |                  |  |
| WHILE AT WORK NOT WHILE AT WORK   |  |         |  |  |        |                                     |      |   |   |                  |  |   |  |                  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner |  |         |  |  |        |                                     |      |   |   |                  |  |   |  |                  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner |  |         |  |  |        |                                     |      |   |   |                  |  |   |  |                  |  |
| ACTUAL SIGNATURE  |  |         |  |  |        |                                     |      |   |   |                  |  | 22b. DATE SIGNED                              |  |                  |  |
| EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.   |  |         |  |  |        |                                     |      |   |   |                  |  | 10-22-68                                      |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |         |  |  |        |                                     |      |   |   |                  |  | 23b. DATE                                     |  |                  |  |
| Burial  |  |         |  |  |        |                                     |      |   |   |                  |  | 10/25/68                                      |  |                  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  |         |  |  |        |                                     |      |   |   |                  |  | 23d. LOCATION (City or Town) (County) (State) |  |                  |  |
| Congressional Cem.  |  |         |  |  |        |                                     |      |   |   |                  |  | Wash., D.C.                                   |  |                  |  |
| 24. FUNERAL DIRECTOR  |  |         |  |  |        |                                     |      |   |   |                  |  | 25a. REC'D BY REGISTRAR                       |  |                  |  |
| Home Inc. Valley's Funeral Maryland   |  |         |  |  |        |                                     |      |   |   |                  |  | OCT 28 1968                                   |  |                  |  |
| 25b. REGISTRAR'S SIGNATURE  |  |         |  |  |        |                                     |      |   |   |                  |  |   |  |                  |  |
| J. Charles Judge  |  |         |  |  |        |                                     |      |   |   |                  |  |   |  |                  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14879

CERTIFICATE OF DEATH

14888

|  |  |  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <i>MARGUERITE</i>  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><i>10-3-68</i>   |  |  | 2b. HOUR<br><i>11:35</i> M  |  |  |
| 3. SEX<br><i>Female</i>  |  |  | 4. RACE<br><i>Cauc.</i>  |  |  | 5. DATE OF BIRTH<br><i>11-12-91</i>   |  |  | 6. AGE (In years last birthday)<br><i>76</i> YRS.   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>New York</i>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><i>Prince Georges</i> Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Forestville</i>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>The Regent Nursing Home</i> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>housewife</i>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br><i>STATE: MD. 10-11-16</i>  |  |  | 13b. COUNTY<br><i>Prince Georges</i>   |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 13e. STREET AND NUMBER<br><i>7537 Broadview Rd.</i>   |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><i>Earnest F. Weed</i>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><i>Lizzi Sawyer</i>   |  |  | 17. INFORMANT<br>Address<br><i>Thomas Hazapis, Son Honolulu, Hawaii (USN)</i>   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br><i>Unknown</i>   |  |  |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pneumonitis</i><br><i>436.9</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Chronic Comatose State</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>C.V.A. &amp; Old Hemiparesis</i> |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>3 days</i><br><i>6 mo</i><br><i>9 mo</i> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><i>331X A.S.H.D. &amp; Chronic Cystitis</i>  |  |  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                        |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19 <i>68</i>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/2</i> 19 <i>68</i> , to <i>10/4</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10/4</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><i>Kelvin L. Minchin</i>   |  |  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  |  | 22c. DATE SIGNED<br><i>10/4/68</i>  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>KELVIN L. MINCHIN</i>   |  |  |  |  |  | 22e. ADDRESS<br><i>6400 Marlboro Pike SE</i>  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>   |  |  | 23b. DATE<br><i>10-7-68</i>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Greenridge Cemetery</i>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Saratoga Springs, N.Y.</i>              |  |  |
| 24. FUNERAL DIRECTOR <i>Wilhelm Funeral Home</i> ADDRESS<br><i>4308 Suitland Rd. SE, Wash. D.C.</i>  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <i>OCT 8 1968</i>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |  |



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14880

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14889

|   |         |                  |  |                 |      |   |      |                          |   |  |          |
|---|---------|------------------|--|-----------------|------|---|------|--------------------------|---|--|----------|
| 1. DECEASED-NAME<br>(Type or Print)   |         |                  | First Middle Last  |                 |      | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED  |      |                          | 2b. HOUR  |  |          |
| George Washington Hazel Jr.   |         |                  |  |                 |      | 10-14-68 19 6   |      |                          | 4:45am  |  |          |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR |      | IF UNDER 24 HRS.  |      | 2c. DATE PRONOUNCED DEAD |   |  | 2d. HOUR |
| Male  | Negro   | 7-10-1932        | 36 YRS.  | MONTHS          | DAYS | HOURS   | MIN. | 10 14 68 19 7:15am M     |   |  |          |
| 7a. BIRTHPLACE (State or foreign country)   |         |                  | 7b. CITIZEN OF WHAT COUNTRY?   |                 |      | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |      |                          | 9. COUNTY OF DEATH  |  |          |
| Washington, D.C.  |         |                  | USA  |                 |      | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                      |      |                          | Prince George's Md.   |  |          |
| 10. CITY OR TOWN OF DEATH   |         |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                 |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |      |                          | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |          |
| Cheverly  |         |                  | Prince George Hospital   |                 |      |   |      |                          |   |  |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                  | 13b. COUNTY  |                 |      | 13c. CITY OR TOWN   |      |                          | 13d. INSIDE CITY LIMITS?  |  |          |
| District of Columbia  |         |                  | Washington   |                 |      |   |      |                          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |
| 14. FATHER'S NAME First Middle Last   |         |                  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |                 |      | 13e. STREET AND NUMBER  |      |                          |   |  |          |
| George Washington Hazel, Sr.  |         |                  | Wilhelmina Kinard  |                 |      | 725 12th. Street N.E.   |      |                          |   |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |                  | 16b. SOCIAL SECURITY NO.   |                 |      | 17. INFORMANT ADDRESS   |      |                          |   |  |          |
|   |         |                  |  |                 |      | George Washington Hazel, Sr. - father   |      |                          |   |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Heart failure<br>4129<br>DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease<br>over 1 yr.<br>minutes<br>over 1 yr.<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>4200 |         |                  |  |                 |      |   |      |                          |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| 19a. DATE OF OPERATION  |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |                 |      | 20. AUTOPSY?  |      |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19                    |                 |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |      |                          |   |  |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                 |      | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |      |                          |   |  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>                              |         |                  |  |                 |      |   |      |                          |   |  |          |
| ACTUAL SIGNATURE  |         |                  | M.D.   |                 |      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |      |                          | 22b. DATE SIGNED  |  |          |
| EXAMINER'S NAME (Type)  |         |                  |  |                 |      | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                     |      |                          | 10-15-68  |  |          |
| John Kehoe MD   |         |                  | Riverdale, Md.   |                 |      | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                             |      |                          | ADDRESS (Street, city, town, or county)                             |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |                  | 23b. DATE  |                 |      | 23c. NAME OF CEMETERY OR CREMATORY  |      |                          | 23d. LOCATION (City or Town) (County) (State)                       |  |          |
| 10/19/68  |         |                  | Lincoln Memorial Cemetery  |                 |      | Maryland  |      |                          |   |  |          |
| 24. FUNERAL DIRECTOR  |         |                  | ADDRESS  |                 |      | 25a. REC'D BY REGISTRAR   |      |                          | 25b. REGISTRAR'S SIGNATURE  |  |          |
| Stewart   |         |                  | Funeral Home-4001 Benning Rd., N.E.  |                 |      | OCT 18 1968   |      |                          | Charles Judge   |  |          |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14881

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14890

|  |  |   |  |
|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Herman Middle Last</b><br><del>XXXXXXXXXXXXXX</del> N. Hebron   |  | 2a. DATE OF DEATH<br>10 Month Day 15 Year 68 5:30 PM  |  |
| 3. SEX <b>Male</b>   | 4. RACE <b>Negro</b>   | 5. DATE OF BIRTH<br>9-4-24  | 6. AGE (In years last birthday)<br>74 YRS.   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Prince Georges</b> Md.                                    |
| 10. CITY OR TOWN OF DEATH<br><b>Riverdale, Maryland</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Leland Memorial</b>                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>  | 13b. CITY OR TOWN<br><b>Prince Georges Brentwood</b>   | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   | 13e. STREET AND NUMBER<br><b>4507 Rhode Island Ave.</b>                            |
| 14. FATHER'S NAME First Middle Last<br><b>John W. Hebron</b>   | 15. MOTHER'S MAIDEN NAME First Middle Last   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)  | 16b. SOCIAL SECURITY NO.<br><b>Unk.</b>  | 17. INFORMANT Address<br><b>Florence Hebron-4507 Rhode Island Ave.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br><b>4109</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 WK</b><br><b>3 WKS</b>        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201 PULMONARY EMBOLISM</b>   |  |   |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>25 SEP. 1968</b> , to <b>15 OCT. 1968</b> , that (I) (we) last saw the deceased alive on <b>15 OCT. 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |
| 22b. SIGNATURE<br><b>C.J. Houmann</b>  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED<br><b>16 OCT 1968</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>C.J. HOUMANN M.D.</b>   | 22e. ADDRESS<br><b>RIVERDALE</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>10-19-68</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Royds, Maryland</b>            |
| 24. FUNERAL DIRECTOR<br><b>John T. Rhines Company Funeral Home</b><br><b>3015 12th street, N.E., Wash., D.C.</b>   | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 21 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                 |

THE UNITED STATES OF AMERICA

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OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |  |  |                        |  |
|--|--|--|--|---|--|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |  |                        |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |                        |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |   |  | 2a. DATE OF DEATH<br>Month Day Year   |  | 2b. HOUR a.m.                            |                        |  |
| Jennie   |  |  | F. Hipple  |   |  | October 5 1968  |  | 7:30 M                                   |                        |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |                        |  |
| Female   |  | White  |  | July 20, 1897   |  | 71 YRS.   |  |  |                        |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |                        |  |
| New York   |  | United States  |  |   |  | Prince George Md.   |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY        |                        |  |
| Hyattsville  |  |  | Sacred Heart Home  |   |  | Clerical  |  |  |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN                        |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER |  |
| Maryland   |  |  | Prince George  |   | Landover                                 |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | 3318 Dodge Park Road   |  |
| 14. FATHER'S NAME<br>First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                |   |  |   |  |  |                        |  |
| Joseph Hipple  |  |  | Jane McKeon  |   |  |   |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address                    |   |  |  |                        |  |
| no   |  |  | 068-09-3507  |   | Sacred Heart Home, Hyattsville, Maryland |   |  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ductile Ulcer - Hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>12 hours</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. <u>5310</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>5420</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic Cardiac - Coronary Arteriosclerosis</u> |  |  |  |   |  |   |  |  |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                    |  |  |                        |  |
|  |  |  |  |   |  |   |  |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |                        |  |
|  |  |  |  |   |  |   |  |  |                        |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |                        |  |
|  |  |  |  |   |  |   |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-3-68</u> to <u>10-3-68</u> , that (I) (we) last saw the deceased alive on <u>10-3-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |                        |  |
| 22b. SIGNATURE <u>Robert C. Hane</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  |   |  | 22c. DATE SIGNED <u>10-5-68</u>   |  |  |                        |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |   |  | 22e. ADDRESS <u>35 NY Ave NW Wash DC</u>  |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |                        |  |
| Burial   |  | 10/7/68  |  | Mt. Olivet Cem.   |  | Wash., D.C.   |  |  |                        |  |
| 24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u> ADDRESS <u>Mt. Rainier, Maryland</u>  |  |  |  | 25a. REC'D BY REGISTRAR DATE <u>OCT 11 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  |  |                        |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14883

14892

|   |  |  |                      |   |  |  |  |  |  |
|---|--|--|----------------------|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>VIRGINIA</b>   |  | First <b>B</b>   | Middle <b>HITNER</b> | Last  | 2a. DATE OF DEATH<br>Month <b>10</b> Day <b>4</b> Year <b>68</b> |  |  | 2b. HOUR<br><b>A</b> M                   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Cauc</b>   |                      | 5. DATE OF BIRTH<br><b>11-5-1880</b>  |  | 6. AGE (In years last birthday)<br><b>87</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Pa.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Prince George</b> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Forestville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Regent Nursing Home</b> |                      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOMEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>  |  | 13b. COUNTY <b>A.A.</b>  |                      | 13c. CITY OR TOWN <b>SHADYSIDE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>—</b>       |  |
| 14. FATHER'S NAME First <b>JOHN E.</b> Middle <b>DORAN</b> Last   |  | 15. MOTHER'S MAIDEN NAME First <b>IDA</b> Middle <b>K. Murphy</b> Last                                     |                      |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |                      | 17. INFORMANT Address<br><b>FRANK M. HITNER #13</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 yrs</b> |  |  |                      |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>4201 Gout &amp; Osteoarthritis Gout's disease</b>  |  |  |                      |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                      | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19 <b>68</b>                                       |                      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |                      | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/5/68</b> to <b>10/4/68</b> , that (I) (we) last saw the deceased alive on <b>10/4/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |                      |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Kelvin L. Minchin</b>  |  | DEGREE<br><b>M.D.</b>  |                      | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  | 22c. DATE SIGNED<br><b>10/4/68</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>KELVIN L. MINCHIN</b>  |  | 22e. ADDRESS<br><b>6400 MARLBORO PINES</b>   |                      |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>10-8-68</b>  |                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON NAT'L.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>ARLINGTON Va.</b>                        |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John M. Taylor &amp; Sons</b>  |  | ADDRESS<br><b>Campania, Md.</b>  |                      | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 7 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |  |

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STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| Item 6 Film 6106 11/8/68  |  |  |  |  |  |  |  |  |  | MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 14888   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 14893   |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) <b>SARAH</b>   |  |  |  |  | First <b>D</b>   |  |  |  |  | Middle <b>HOAN</b>  |  |  |  |  | Last   |  |  |  |  | 2a. DATE OF DEATH<br>Month <b>10</b> Day <b>25</b> Year <b>1968</b>     |  |  |  |  | 2b. HOUR <b>8:34</b> M                   |  |  |  |  |
| 3. SEX <b>Female</b>  |  |  |  |  | 4. RACE <b>White</b>   |  |  |  |  | 5. DATE OF BIRTH <b>7-7-88</b>  |  |  |  |  | 6. AGE (In years last birthday) <b>80</b> YRS.   |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS <b>11</b> DAYS <b>14</b> HOURS <b>14</b> MIN. |  |  |  |  | IF UNDER 24 HRS.<br>HOURS <b>14</b> MIN. |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>U.S.A</b>  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>        |  |  |  |  | 9. COUNTY OF DEATH <b>Prince George</b> Md.  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Clinton</b>  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pine View Garden</b> |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>   |  |  |  |  | 13b. COUNTY <b>Mont.</b>   |  |  |  |  | 13c. CITY OR TOWN <b>Beth.</b>  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER <b>9807 River Rd.</b>                            |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First <b>ISAAC</b>  |  |  |  |  | Middle <b>JOHNSON</b>  |  |  |  |  | Last  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>JOHNSON</b>  |  |  |  |  | Middle <b>JOHNSON</b>   |  |  |  |  | Last <b>JOHNSON</b>                      |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT   |  |  |  |  |  |  |  |  |  | Address   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Circulatory collapse</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>C. V. A. Cerebrovascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic hypertensive disease</b> |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                            |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>331X</b>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-28</b> , 19 <b>67</b> , to <b>10-25</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-24</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>Alfred R. Lapina</b>  |  |  |  |  |  |  |  |  |  | DEGREE <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>ALFRED R. LAPINA</b>  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS <b>CLINTON, MD</b>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  |  |  |  | 23b. DATE <b>10-28-68</b>  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Wyoming Cemetery</b>  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) <b>Grandville, Michigan</b>                    |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home 4308 Suitland Rd. S. E.</b>  |  |  |  |  |  |  |  |  |  | ADDRESS   |  |  |  |  | 25a. REC'D BY REGISTRAR <b>NOV 1 1968</b>  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                         |  |  |  |  |  |  |  |  |  |

H.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                              |  |  |   |  |  |  |                        |
|---|--|------------------------------|--|--|---|--|--|--|------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                              |  |  |   |  |  |  |                        |
| CERTIFICATE OF DEATH  |  |                              |  |  |   |  |  |  |                        |
| 14885   |  |                              |  |  |   |  |  |  |                        |
| 14894   |  |                              |  |  |   |  |  |  |                        |
| 1. DECEASED-NAME<br>(Type or print)   |  |                              | First Middle Last  |  |   | 2a. DATE OF DEATH  |  |  | 2b. HOUR               |
| William H. Hooker   |  |                              |  |  |   | Oct. 13, 1968  |  |  | 10:30 <sup>PM</sup>    |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH   |   |  | 6. AGE (In years lost birthday)  |  | IF UNDER 1 YEAR        |
| Male  |  | Caucasian                    |  | Jan. 25, 1892  |   |  | 76   |  | MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |  |                        |
| Washington D C  |  | U S A                        |  |  |   | Prince George's Md.  |  |  |                        |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                        |
| Cheverly  |  |                              | Prince Geo.Gen'l Hospital  |  |   | Retired clerk  |  | Iron Works   |                        |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER |
| Maryland  |  |                              | Prince George's  |  | Hyattsville   |  | YES  |  | 7416 Allison Street    |
| 14. FATHER'S NAME   |  |                              | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |                        |
| Charles Hooker  |  |                              | Minnie Dreschler   |  |   |  |  |  |                        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | Address  |  |                        |
| no  |  |                              | 578 17 3789A   |  | Minnie O' Connor  |  | Hyattsville, Md.   |  |                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u><br>185X DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause }<br>(b) <u>Carcinoma of prostate</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 days<br>2 yrs. |  |                              |  |  |   |  |  |  |                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>177X  |  |                              |  |  |   |  |  |  |                        |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                        |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |  |  |                        |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |  |  |                        |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/9/1964, to 10/13/1968, that (I) (we) last saw the deceased alive on 10/13/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.  |  |                              |  |  |   |  |  |  |                        |
| 22b. SIGNATURE  |  |                              |  |  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED   |                        |
| 22d. PHYSICIAN'S NAME (Type)  |  |                              |  |  |   | 22e. ADDRESS   |  |  |                        |
| Frederick E. Musser, M. D.  |  |                              |  |  |   | 4410 74th Ave. Bellmead, Md. 20784   |  |  |                        |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |                        |
| Burial  |  |                              | Oct 16, 1968   |  | Cedar Hill Cemetery   |  | Suitland Pro Geo Md.   |  |                        |
| 24. FUNERAL DIRECTOR ADDRESS  |  |                              |  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |                        |
| F. Gasch's Sons Hyattsville, Md   |  |                              |  |  | DATE OCT 16 1968  |  | Charles Judge  |  |                        |





14886

## CERTIFICATE OF DEATH

|  |         |  |                  |  |  |   |  |  |                  |
|--|---------|--|------------------|--|--|---|--|--|------------------|
| 1. DECEASED-NAME<br>(Type or print)  |         | First  | Middle           | Last   | 2a. DATE OF DEATH  |   |  | 2b. HOUR                                     |                  |
| LOTTIE   |         |  |                  | HUTCHINGS  | Month  | Day   | Year   | 2:06 PM                                      |                  |
| 3. SEX   | 4. RACE |  | 5. DATE OF BIRTH |  | 6. AGE (In years last birthday)  |   | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS. |
| Female   | White   |  | Feb-7-1877       |  | 91 YRS.  |   | MONTHS   |  | HOURS            |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |                  |
| N. Carolina  |         | U. S. A.   |                  |  |  | Prince Georges Md.  |  |  |                  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |                  |
| Adelephi   |         | 2717 Hughes Road   |                  | at Home  |  | Same  |  |  |                  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) STATE   |         | 13b. COUNTY  |                  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |                  |
| Md   |         | On Geo   |                  | Adelephi   |  |   |  | 2717 Hughes Road                             |                  |
| 14. FATHER'S NAME  |         | First  | Middle           | Last   | 15. MOTHER'S MAIDEN NAME   |   | First  | Middle                                       | Last             |
| Sheldon  |         |  |                  | White  | Marion   |   |  |  | Hare             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |         | 16b. SOCIAL SECURITY NO.   |                  | 17. INFORMANT  |  | Address   |  |  |                  |
|  |         |  |                  | Mr. Juanita M. Guild   |  | (same as #2)  |  |  |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |                  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |
| PART 1. DEATH WAS CAUSED BY:   |         |  |                  |  |  |   |  |  |                  |
| IMMEDIATE CAUSE (a) Anteriosclerotic heart disease   |         |  |                  |  |  |   |  | 10 yrs.                                      |                  |
| 4129 DUE TO, OR AS A CONSEQUENCE OF  |         |  |                  |  |  |   |  |  |                  |
| (b) Senility   |         |  |                  |  |  |   |  |  |                  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |                  |  |  |   |  |  |                  |
| (c) Anteriosclerosis   |         |  |                  |  |  |   |  | 12 yrs.                                      |                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |  |                  |  |  |   |  |  |                  |
| 4200   |         |  |                  |  |  |   |  |  |                  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                  |
|  |         |  |                  |  |  |   |  |  |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |         | 21b. TIME OF INJURY  |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |                  |
|  |         | HOUR A.M. Month Day Year P.M. 19   |                  |  |  |   |  |  |                  |
| 21d. INJURY OCCURRED   |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  | 21f. LOCATION  |  | City or Town  |  | County State                                 |                  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |         |  |                  |  |  |   |  |  |                  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1957, 19, to Oct. 26, 1968, that (I) (we) last saw the deceased alive on 10/24/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         |  |                  |  |  |   |  |  |                  |
| 22b. SIGNATURE   |         |  |                  |  |  |   |  | 22c. DATE SIGNED                             |                  |
| A.W. Smith M.A.  |         |  |                  |  |  |   |  | 10/26/68                                     |                  |
| 22d. PHYSICIAN'S NAME (Type)   |         | A.W. SMITH   |                  | 22e. ADDRESS   |  | 13018 GEORGIA AVE WHEATON, MD.  |  |  |                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town)  |  | (County) (State)                             |                  |
| Burial   |         | Oct. 29, 1968  |                  | Ford Lincoln Cemetery  |  | Colman Manor  |  | Md   |                  |
| 24. FUNERAL DIRECTOR   |         |  |                  | ADDRESS  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                   |                  |
| J. W. Wallers  |         |  |                  | 254 Canal Blvd WDC   |  | OCT 29 1968   |  | J. Charles Judge                             |                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14662

CERTIFICATE OF DEATH

1987

1987

1. Name of deceased  
2. Sex  
3. Race  
4. Date of birth  
5. Date of death  
6. Place of death  
7. Cause of death  
8. Signature of physician  
9. Signature of registrar

10. Name of informant  
11. Address of informant  
12. Signature of informant  
13. Date of completion  
14. Signature of registrar

15. Name of registrar  
16. Address of registrar  
17. Signature of registrar  
18. Date of completion  
19. Signature of registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 11-66

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |  |   |  |  |   |   |  |   |                                 |  |                |  |  |                                 |  |  |            |  |  |                   |  |  |  |
|--|--|--|---|--|--|---|--|--|---|---|--|---|---------------------------------|--|----------------|--|--|---------------------------------|--|--|------------|--|--|-------------------|--|--|--|
| Item 3 Film G405 10/21/68  |  |  |   |  |  |   |  |  |   |   |  |   |                                 |  |                |  |  |                                 |  |  |            |  |  |                   |  |  |  |
| 14887  |  |  |   |  |  |   |  |  |   |   |  |   |                                 |  |                |  |  |                                 |  |  |            |  |  |                   |  |  |  |
| 14896  |  |  |   |  |  |   |  |  |   |   |  |   |                                 |  |                |  |  |                                 |  |  |            |  |  |                   |  |  |  |
| CERTIFICATE OF DEATH   |  |  |   |  |  |   |  |  |   |   |  |   |                                 |  |                |  |  |                                 |  |  |            |  |  |                   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br>NORA   |  |  | Middle<br>A   |  |  | Last<br>HUTTEL  |   |  | 2a. DATE OF DEATH<br>16                           |                                 |  | Month<br>Oct   |  |  | Day<br>16                       |  |  | Year<br>68 |  |  | 2b. HOUR<br>11:50 |  |  |  |
| 3. SEX<br>Female<br>MALE   |  |  | 4. RACE<br>WHITE  |  |  | 5. DATE OF BIRTH<br>25 Jan. 1888  |  |  | 6. AGE (In years<br>last birthday)<br>80 YRS.   |   |  | IF UNDER 1 YEAR<br>MONTHS<br>8                    |                                 |  | DAYS<br>21     |  |  | IF UNDER 24 HRS.<br>HOURS<br>11 |  |  | MIN.<br>50 |  |  |                   |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>BUFFALO, NEW YORK  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>PRINCE GEORGES COUNTY Md.   |   |  |   |                                 |  |                |  |  |                                 |  |  |            |  |  |                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>FORESTVILLE, MD.  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>4101-SUIT ROAD |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>HOUSEWIFE   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>HOME MAKER  |   |  |   |                                 |  |                |  |  |                                 |  |  |            |  |  |                   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>D.C.   |  |  | 13b. COUNTY<br>D.C.   |  |  | 13c. CITY OR TOWN<br>WASH. D.C.   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  | 13e. STREET AND NUMBER<br>2600-QUEENS CHAPEL ROAD |                                 |  | D.N.E.         |  |  |                                 |  |  |            |  |  |                   |  |  |  |
| 14. FATHER'S NAME  |  |  | First<br>WILLIAM KURTZ  |  |  | Middle<br>Last  |  |  | 15. MOTHER'S MAIDEN NAME  |   |  | First<br>AMELIA KURTZ                             |                                 |  | Middle<br>Last |  |  |                                 |  |  |            |  |  |                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)   |  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)                                 |  |  | 17. INFORMANT<br>FORESTVILLE, MARYLAND<br>JOHN W. HUTTEL (SON) 4101 SUIT ROAD.  |  |  |   |   |  |   |                                 |  |                |  |  |                                 |  |  |            |  |  |                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac arrest<br>4129<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) Arteriosclerotic heart disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Failure of pacemaker |  |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |   |                                 |  |                |  |  |                                 |  |  |            |  |  |                   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br>4200   |  |  |   |  |  |   |  |  |   |   |  |   |                                 |  |                |  |  |                                 |  |  |            |  |  |                   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |   |  |   |                                 |  |                |  |  |                                 |  |  |            |  |  |                   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |   |  |   |                                 |  |                |  |  |                                 |  |  |            |  |  |                   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                   |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |   |  |   |                                 |  |                |  |  |                                 |  |  |            |  |  |                   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept. 1, 1966, to 16 Oct., 1968, that (I) (we) last<br>saw the deceased alive on 11 Oct., 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |   | 22b. SIGNATURE<br>Thomas E. Mattingly, M.D.     |  |   | 22c. DATE SIGNED<br>16 Oct 1968 |  |                |  |  |                                 |  |  |            |  |  |                   |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  |  | Thomas E. Mattingly, M.D.   |  |  | 22e. ADDRESS<br>2200 Rhode Is. Ave. N.E. D.C.   |  |  |   |   |  |   |                                 |  |                |  |  |                                 |  |  |            |  |  |                   |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL   |  |  | 23b. DATE<br>10/18/1968   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CEDAR HILL CEMETERY   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>SUITLAND, MARYLAND                             |   |  |   |                                 |  |                |  |  |                                 |  |  |            |  |  |                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>MARTIN W. HYSONG COMPANY   |  |  | 25a. REC'D BY REGISTRAR<br>DATE OCT 18 1968   |  |  | 25b. REGISTRAR'S SIGNATURE<br>J. Charles Judge  |  |  |   |   |  |   |                                 |  |                |  |  |                                 |  |  |            |  |  |                   |  |  |  |

14884

07:11:50 Oct 16 1968

25 Jan. 1968

PRINCE GEORGE COUNTY

ROBERTA

2000-10-16

AMITA KUMAR

WILLIAM KUMAR

FOR BIRTH, HAWAII  
JOHN A. HUNTER (SON) 1010 1010

Cardiac arrest

arterio-sclerotic heart disease

failure of myocardium

11 Oct. 1968

Thomas ... ttingly, 2200 ... D.C.

10/14/1968 ORDER WILL CEMETERY

Oct 16 1968

10/16/1968

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14888

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14897

|   |                  |   |        |   |   |   |   |
|---|------------------|---|--------|---|---|---|---|
| 1. DECEASED-NAME<br>(Type or Print)   |                  | First   | Middle | Last  | 2a. DATE KNOWN OF DEATH ESTIMATED<br><input checked="" type="checkbox"/> Month Day Year<br>10/30/1968 |   | 2b. HOUR<br>685/40P                                     |
| Margaret  |                  | S   |        | Jones   |   |   |   |
| 3. SEX<br>female  | 4. RACE<br>white | 5. DATE OF BIRTH<br>March 1, 1884   |        | 6. AGE (In years last birthday)<br>84 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS<br>HOURS MIN.   |   |
| 7a. BIRTHPLACE (State or foreign country)<br>Alabama  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>           |   | 9. COUNTY OF DEATH<br>Prince George's Md.   |   |
| 10. CITY OR TOWN OF DEATH<br>Lanham   |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Magnolia Nursing Home |        |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>housewife  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>home               |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md   |                  | 13b. COUNTY<br>Pro George's   |        | 13c. CITY OR TOWN<br>Riverdale  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  | 13e. STREET AND NUMBER<br>6321 Kenilworth avenue,.                                  |   |
| 14. FATHER'S NAME<br>Henry C Smilie   |                  | First   | Middle | Lost  | 15. MOTHER'S MAIDEN NAME<br>Ella Parker   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>no   |                  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)                                     |        | 17. INFORMANT<br>Ella Spicer  |   |   |   |
|   |                  |   |        | ADDRESS<br>Riverdale, Md.   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pulmonary embolus<br>887X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                  |   |        |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Minutes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>9040 Arteriosclerotic heart disease- yrs. Fracture rt femur 15 days  |                  |   |        |   |   |   |   |
| 19a. DATE OF OPERATION<br>17 Oct  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br>Fracture 6d left femur                           |        |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/><br>CAUSE OF DEATH  |                  | 21b. TIME OF INJURY Month, Day, Year<br>6:30pm 10 15 19 68  |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Died at home   |   |   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>home                  |        | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>6321 Kenilworth Ave., Hyattsville P.G. Md.  |   |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |   |        |   |   |   |   |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)  |                  | John Kehoe, M.D., Riverdale   |        | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   | 22b. DATE SIGNED<br>10-30-68  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                  | 23b. DATE<br>Nov 2, 1968  |        | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft Lincoln Cemetery   |   | 23d. LOCATION (City or Town) (County) (State)<br>Colmar Manor Pro Geo Md.           |   |
| 24. FUNERAL DIRECTOR<br>F. Gasch's Sons Hyattsville, Md.  |                  |   |        | 25a. REC'D BY REGISTRAR<br>DATE NOV 4 1968  |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-7-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |  |  |
| 14899 CERTIFICATE OF DEATH 14898  |  |  |  |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>THETUS A. JORDAN</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>Oct</b> Day <b>25</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>4A.M.</b>  |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br><b>OCT 14, 1912</b>   |  | 6. AGE (In years last birthday)<br><b>56</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>56</b> DAYS <b>00</b> HOURS <b>00</b> MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>NORTH CAROLINA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>PRINCE GEORGES</b> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CHEVERLY</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>PRINCE GEORGES GEN HOSPITAL</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>R.R. CAR CLEANER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>D.C.</b>  |  | 13b. COUNTY<br><b>D.C.</b>   |  | 13c. CITY OR TOWN<br><b>WASHINGTON</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>724 HAMLIN ST. N.E.</b>                       |  |
| 14. FATHER'S NAME First Middle Last<br><b>JAMES ALLEN</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>MAUDE UNDERWOOD</b> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>R.R. RETIREMENT</b>   |  | 17. INFORMANT<br><b>CHARLOTTE SHERRY</b> Address <b>3620 WATFIELD CHAPEL RD LANHAM MD.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br><b>2509</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <b>260x</b><br>(b) <b>Arteriosclerotic Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus</b> |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Hypertension for at least 20 years</b>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-6</b> , 19 <b>49</b> , to <b>10-25</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-21</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Claudine M. Gay MD</b>   |  | 22c. DATE SIGNED<br><b>10-26-68</b>  |  | 22d. PHYSICIAN'S NAME (Type) <b>CLAUDINE M. GAY, MD</b>   |  |   |  |  |  |
| 22e. ADDRESS<br><b>403 E CAPITOL ST WASH. DC</b>  |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>Oct 28, 1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FORT LINCOLN CEM</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>COLMAR MANOR MARYLAND</b>                   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>W. W. CHAMBERS CO. RIVERDALE, MD.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>NOV 6 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| <div style="display: flex; justify-content: space-between;"> <div> 14890<br/> <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH<br/> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br/> <b>CERTIFICATE OF DEATH</b> </div> </div> <div> 14899 </div> </div>  |  |  |   |  |  |   |  |  |   |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First <del>ANNA</del> <b>ANNA</b> Middle <b>B.</b> Last <b>KASH</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>OCT</b> Day <b>13</b> Year <b>1968</b>  |  |  | 2b. HOUR<br><b>4:30 PM</b>  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  |  | 4. RACE<br><b>CAU.</b>  |  |  | 5. DATE OF BIRTH<br><b>15 JAN. 1887</b>   |  |  | 6. AGE (In years last birthday)<br><b>81</b> YRS.   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>KENTUCKY</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Princ George</b> Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>GREENBELT</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GREENBELT NURSING HOME</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>RET. TEACHER</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PUBLIC SCHOOL</b>                                       |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  |  | 13b. CITY OR TOWN<br><b>PRINCE GEORGE</b>   |  |  | 13c. CITY OR TOWN<br><b>GREENBELT</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br><b>26 WOODLAND WAY</b>   |  |  | 14. FATHER'S NAME First Middle Last<br><b>PLEASANT B. BROADDUS</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>MARY C. COCKRELL</b>   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, <b>NO</b> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.<br><b>405-28-6609</b>  |  |  | 17. INFORMANT<br><b>HOWARD B. KASH SON SAME AS ABOVE</b>  |  |  | Address   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>486X</b><br>(b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>① Cerebral Arteriosclerosis ② Substernal Thyroid compressing trachea</b> |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b>                                 |  |  |
|  |  |  |   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 1968</b> to <b>Oct 13, 1968</b> , that (I) (we) last saw the deceased alive on <b>10-13</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>William C. Wentz MD</b>   |  |  |   |  |  | 22c. DATE SIGNED  |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |   |  |  | 22e. ADDRESS  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>10/16/68</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HILLCREST MEMORIAL PARK</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>LEXINGTON KENTUCKY</b>                      |  |  |
| 24. FUNERAL DIRECTOR<br><b>F. GASCH'S SONS</b>   |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br><b>HYATTSVILLE, MARYLAND</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>OCT 16 1968</b>  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

| 1. DECEASED-NAME<br>(Type or print)  |  |   |  | First   | Middle | Lost   | 2a. DATE OF DEATH<br>Month Day Year        |  |                                      | 2b. HOUR                                     |   |
|--|--|---|--|---|--------|--|--|--|--------------------------------------|--|---|
| Baby Girl Keenan   |  |   |  |   |        |  | Oct.                                       | 22.  | 1968                                 | 9:10PM                                       |   |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>Oct. 22, 1968   |        |  | 6. AGE (In years<br>lost birthday)<br>YRS. |  | IF UNDER 1 YEAR<br>MONTHS DAYS       |  | IF UNDER 24 HRS.<br>HOURS MIN.                  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. COUNTY OF DEATH<br>Prince George's Md.  |  |  |                                      |  |   |
| 10. CITY OR TOWN OF DEATH<br>Cheverly  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Prince Geo.Gen'l Hospital |   |        | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland   |  |   | 13b. COUNTY<br>Prince George's   |   |        | 13c. CITY OR TOWN<br>E.Riverdale   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                      | 13e. STREET AND NUMBER<br>5519 Nicholson St. |   |
| 14. FATHER'S NAME<br>Charles E. Keenan   |  |   | 15. MOTHER'S MAIDEN NAME<br>Patricia Stockstill  |   |        |  |  |  |                                      |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  |   | 16b. SOCIAL SECURITY NO.   |   |        | 17. INFORMANT<br>Address   |  |  |                                      |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Anomalous placental previa</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                             |  |   |  |   |        |  |  |  |                                      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |        |  |  |  |                                      |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |   |        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?              |                                      |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |        |  |  |  |                                      |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |        |  |  |  |                                      |  |   |
| 22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <u>Oct. 22, 1968</u> , to <u>Oct. 22, 1968</u> , that (I) <del>(we)</del> last<br>saw the deceased alive on <u>Oct. 22, 1968</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the<br>causes stated above, (I) <del>(we)</del> <del>(did not)</del> view the body after death. |  |   |  |   |        |  |  |  |                                      |  |   |
| 22b. SIGNATURE<br><u>Iradij Mahadavi, M. D.</u>  |  |   |  |   |        | DEGREE<br>ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br>Oct. 24, 1968  |                                      |  |   |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Iradij Mahadavi, M. D.  |  |   |  |   |        | 22e. ADDRESS<br>6821 Riverdale Rd., Riverdale, Md. 20840   |  |  |                                      |  |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE<br>11-2-68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Prince George's General<br>Hospital   |        | 23d. LOCATION (City or Town) (County) (State)<br>Cheverly, Maryland  |  |  |                                      |  |   |
| 24. FUNERAL DIRECTOR<br><u>Harry W. Penn, Jr., Administrator</u>   |  |   |  |   |        | 25a. REC'D BY REGISTRAR<br>DATE NOV 6 1968   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                   |                                      |  |   |

81-28206

CONFIDENTIAL

DATE: 10/21/1981

TO: [illegible]

FROM: [illegible]

[illegible]

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14892

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14901

|   |                         |   |   |  |   |
|---|-------------------------|---|---|--|---|
| 1. DECEASED NAME<br>(Type or Print)<br>First Middle Last<br><b>Theodore Lewis Keys</b>  |                         |   | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br><b>10-21-68</b>  |  | 2b. HOUR<br>:45pm   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Negro</b> | 5. DATE OF BIRTH<br><b>5-8-1937</b>   | 6. AGE (In years last birthday)<br><b>31</b> YRS.   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>10 22 68</b>  |   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>D.C.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Prince George's</b>                        |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince George Hospital</b>   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                      |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>District of Columbia</b>  |                         | 13b. COUNTY<br><b>Washington</b>  | 13c. CITY OR TOWN<br><b>Washington</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              | 13e. STREET AND NUMBER<br><b>1409 15th. Street N.W.</b>             |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Nathan Keys</b>  |                         | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Juanita Bates</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>Yes</b>   |                         | 16b. SOCIAL SECURITY NO.<br>(If yes, give number and dates of service)<br><b>WWII 577-50-2552</b>   |   | 17. INFORMANT ADDRESS<br><b>Donna Keys 4545 Wheeler Rd SE, D.C.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral hemothorax</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Gun shot wounds of chest</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |                         |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>981X</b>  |                         |   |   |  |   |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br><b>11:44pm 10-21-19 68</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Shot by assailant.</b> |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Parking lot of 1500 Southern Ave., Prince George's County, Maryland</b>            |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>Prince George's County, Maryland</b>      |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |   |   |  |   |
| ACTUAL SIGNATURE<br><b>John Kehoe</b>   |                         | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   | 22b. DATE SIGNED<br><b>10-22-68</b>  |   |
| EXAMINER'S NAME (Type)<br><b>John Kehoe MD</b>  |                         | RIVERDALE, Md.  |   | ADDRESS (Street, city, town, or county)  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                         | 23b. DATE<br><b>Oct 26, 1968</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HARMONY MEM. Park</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Landover Md</b> |
| 24. FUNERAL DIRECTOR<br><b>JOHNSON &amp; JENKINS FUN. HOME INC.</b>   |                         | ADDRESS<br><b>4804 GA. AVE NW WASH. D.C.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>OCT 28 1968</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                  |

14501

WFO CAN EXAMINER 7 (EXAMINER OF STAFF)

14502

ON STAFF  
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• FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |  |  |   |  |   |  |   |  |  |  |
|---|---------|--|--|---|--|---|--|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |  |  |   |  |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or Print)   |         | First  |  | Middle  |  | Last  |  | 2. DATE KNOWN OF DEATH                                      |  | 2b. HOUR                                     |  |
| Elijah  |         | M.   |  | Kinney  |  |   |  | Month Day Year<br>10-8 1968                                 |  | 3:40 PM                                      |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR                                     |  | IF UNDER 24 HRS   |  | 2c. DATE PRONOUNCED DEAD                     |  |
| M   | Negro   | 2-8-1912   |  | 56 YRS.   |  | MONTHS DAYS   |  | HOURS MIN.  |  | Month Day Year<br>10 8 1968                  |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  | 9. COUNTY OF DEATH                                  |  |   |  |  |  |
| Virginia  |         | U.S.A.   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                      |  | Prince George                                       |  |   |  | Md.  |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                   |  |   |  |  |  |
| Glendale, Md.   |         | Glendale Hosp.   |  | Street Cleaner  |  | ---   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?                            |  | 13e. STREET AND NUMBER                                      |  |  |  |
| DC  |         | Washington   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 24 Bryant St., N.E.                                 |  |   |  |  |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |   |  |  |  |
| First Middle Last   |         | First Middle Last  |  |   |  |   |  |   |  |  |  |
| Thomas F. Kinney  |         | Mary -- Miner  |  |   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |  |  |
|   |         | 577-50-9399  |  | Decedent  |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |         |  |  |   |  |   |  |   |  | hrs.   |  |
| IMMEDIATE CAUSE (a) Acute Barbiturate intoxication  |         |  |  |   |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |   |  |   |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |         |  |  |   |  |   |  |   |  |  |  |
| (b)   |         |  |  |   |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |   |  |   |  |   |  |  |  |
| (c)   |         |  |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)   |         |  |  |   |  |   |  |   |  |  |  |
| 871.7   |         |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  | 20. AUTOPSY?  |  |   |  |   |  |  |  |
|   |         |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  |   |  |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>  |         | 21b. TIME OF INJURY Month, Day, Year   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |   |  |   |  |  |  |
| CAUSE OF DEATH  |         | pm P.M. 10-8 19 68   |  | Unknown -Took overdose of barbiturate   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County  |  | State  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         | Hospital   |  | Glendale  |  | Glendale  |  | P.G.  |  | Md.  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> |         |  |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE  |         | John Kehoe, M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED                             |  |
| EXAMINER'S NAME (Type)  |         |  |  | ADDRESS (Street, city, town, or county)   |  |   |  |   |  | 32- 2-14-68                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town)                        |  | (County)  |  | (State)                                      |  |
| Burial  |         | 10-9-68  |  | Lincoln Memorial  |  | Suitland, Maryland                                  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR  |         | ADDRESS  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                          |  |   |  |  |  |
| Peyton Funeral Home, 2205 Shirlington, Virginia   |         | Arlington  |  | FEE 19 1969   |  | Charles Judge                                       |  |   |  |  |  |

Replacement certificate

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14894

CERTIFICATE OF DEATH

14903

|   |  |  |  |   |   |  |   |  |  |  |                                 |  |
|---|--|--|--|---|---|--|---|--|--|--|---------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Anna</b>   |  | First <b>E.</b>  |  | Middle <b>Kirby</b>   |   | Last   |   | 2a. DATE OF DEATH<br>Month <b>October</b> Day <b>12</b> Year <b>1968</b> |  |  | 2b. HOUR <b>4:45</b> P <b>M</b> |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>December 16, 1877</b>  |   |  | 6. AGE (In years last birthday)<br><b>90</b> YRS.                         |  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> |                                 | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>                 |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Washington, D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. COUNTY OF DEATH<br><b>Prince George</b> Md.                            |  |  |  |                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hyattsville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Sacred Heart Home</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housework</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |                                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>District</b>   |  | 13b. COUNTY <b>of Columbia</b>   |  | 13c. CITY OR TOWN<br><b>Washington</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>1046 Wisconsin Avenue, N.W.</b>             |  |  |                                 |  |
| 14. FATHER'S NAME First <b>Kearns</b> Middle <b>Andrew</b> Last <b>Kirby</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>E.</b> Last <b>McCormick</b>   |   |  |   |  |  |  |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>216-46-7225</b>   |  | 17. INFORMANT Address<br><b>Sacred Heart Home Hyattsville, Maryland</b>   |   |  |   |  |  |  |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4109</b> IMMEDIATE CAUSE (a) <b>Coronary thrombosis &amp; myocardial infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                 |  |  |  |   |   |  |   |  |  |  |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 hours</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>   |  |  |  |   |   |  |   |  |  |  |                                 |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?     |  |  |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |  |  |  |                                 |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |   |  |  |  |                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-28</b> , 19 <b>59</b> , to <b>10-12</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-12</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death. |  |  |  |   |   |  |   |  |  |  |                                 |  |
| 22b. SIGNATURE<br><b>Thomas F Collins</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  |   |   |  |   | 22c. DATE SIGNED<br><b>10-12-68</b>                                      |  |  |                                 |  |
| 22d. PHYSICIAN'S NAME (Type) <b>THOMAS F COLLINS</b>  |  |  |  |   |   |  |   | 22e. ADDRESS<br><b>325-H 01 NE</b>                                       |  |  |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>Oct. 15, 1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington, D. C.</b> |  |  |  |                                 |  |
| 24. FUNERAL DIRECTOR<br><b>W. J. McDonough - Murphy &amp; H. Art. Vis.</b> ADDRESS  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>OCT 15 1968</b> DATE  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |  |  |  |                                 |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
30M REV. 7/68

| 14895  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 14904  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print)   |  |  |  | First Middle Last  |  |  |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR  |  |  |  |
| MARY   |  |  |  | PAGE KNAPP   |  |  |  | Month Day Year<br>October 10 1968  |  |  |  | 3A.M  |  |  |  |
| 3. SEX<br>Female   |  |  |  | 4. RACE<br>White   |  |  |  | 5. DATE OF BIRTH<br>November 28, 1884  |  |  |  | 6. AGE (In years last birthday)<br>83 YRS.  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Virginia  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  | 9. COUNTY OF DEATH<br>Prince Georges Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Upper Marlboro, Md.   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>XXXXXX Church Road   |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>STATE Maryland  |  |  |  | 13b. CITY OR TOWN<br>Prince Georges  |  |  |  | 13c. CITY OR TOWN<br>Upper Marlboro  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Henry Deane Page  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>XXXXXX Sarah Gregg   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) NO  |  |  |  | 16b. SOCIAL SECURITY NO.  |  |  |  |
| 17. INFORMANT<br>Mr. John Page -   |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4129 Myocardial insufficiency<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) arteriosclerotic heart disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) generalized arteriosclerosis<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4200 |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>years<br>years<br>years  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner) |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  | 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  |  |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State  |  |  |  | 22a. I certify that (I) (the hospital) attended the deceased from 1943, to 10/10/68, 19, that (I) (we) last saw the deceased alive on 10/10/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  | 22b. SIGNATURE<br>Emily H. Wilson M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |
| 22c. DATE SIGNED<br>10/11/68   |  |  |  | 22d. PHYSICIAN'S NAME (Type)<br>Emily H. Wilson, M.D.  |  |  |  | 22e. ADDRESS<br>Lothian, Maryland 20820  |  |  |  | 22f. REC'D BY REGISTRAR<br>DATE OCT 16 1968   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  |  | 23b. DATE<br>Oct. 12, 1968   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Barnabas Episc. Leland Pr. Geor Md.  |  |  |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |
| 24. FUNERAL DIRECTOR<br>Ritchie Bros. Funeral Home Md.   |  |  |  | 25a. ADDRESS<br>Upper Marlboro   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>J. Charles Judge   |  |  |  | 25c. DATE<br>OCT 16 1968  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |  |  |   |  |   |
|---|--|--|--|---|--|--|--|---|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |   |  |   |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |   |
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br><b>Lena</b>   |  | Middle<br><b>E.</b>   |  | Last<br><b>KNOX</b>  |  | 2a. DATE OF DEATH<br><b>Oct.</b> Month <b>28</b> , Day <b>1968</b> or |  | 2b. HOUR<br><b>10:25</b> PM                     |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br><b>12-03-06</b>   |  | 6. AGE (In years<br>lost birthday)<br><b>61</b> YRS.                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN                   |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Va</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Prince George's</b>   |  | Md.   |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Prince George's Gen'l Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Retired phone operator</b>                                 |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |   |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Anne Arundel</b>   |  | 13c. CITY OR TOWN<br><b>Annapolis</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>Severn Grove Circle</b>                  |  |   |
| 14. FATHER'S NAME   |  | First<br><b>George Turner</b>  |  | Middle<br><b>Hepner</b>   |  | Last<br><b>Terzah</b>  |  | MOTHER'S MAIDEN NAME First<br><b>Amelia</b>                           |  | Address<br><b>Celler</b>                        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>578 10 0702</b>                                  |  | 17. INFORMANT<br><b>Herman T Knox</b>   |  | Address<br><b>Annapolis, Md.</b>   |  |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>carcinomatosis</b>   |  |  |  |   |  |  |  |   |  |   |
| 174X DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |   |  |   |
| Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.   |  |  |  |   |  |  |  |   |  |   |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |  |   |  |   |
| (c) <b>adenocarcinoma of the breast</b>   |  |  |  |   |  |  |  |   |  | <b>18-month</b>                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |   |  |   |
| 170X  |  |  |  |   |  |  |  |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? <b>Yes</b>   |  |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory,<br>office building, etc.)  |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |  | County  |  | State   |
| 22a. I certify that (I) <del>(the doctor)</del> attended the deceased from <b>March</b> , 19 <b>67</b> , to <b>Oct. 28</b> , 19 <b>68</b> , that (I) <del>(we)</del> last<br>saw the deceased alive on <b>Oct. 28</b> , 19 <b>68</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the<br>causes stated above, (I) <del>(we)</del> (did) <del>(not)</del> view the body after death. |  |  |  |   |  |  |  |   |  |   |
| 22b. SIGNATURE<br><b>Don B Cameron</b>  |  | DEGREE   |  | ATTENDING<br>PHYS. <input checked="" type="checkbox"/>  |  | MED. DIRECTOR <input type="checkbox"/>   |  | STAFF<br>PHYS. <input type="checkbox"/>                               |  | 22c. DATE SIGNED<br><b>Oct. 28, 1968</b>        |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>Don B. Cameron, M. D.</b>   |  | 22e. ADDRESS<br><b>3503 Perry St., Mt. Rainier, Md. 20822</b>  |  |   |  |  |  |   |  |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>Nov 1, 1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Colmar Manor, Pro Geo Md.</b>    |  |   |  |   |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b>  |  | ADDRESS<br><b>Hyattsville, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>NOV 4 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                   |  |   |  |   |

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1993, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

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Primo George, a Canadian biologist

• *Journal of Management Education* 25(1): 10-14

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CONFIDENTIAL

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 13b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |                              |  |   |      |  |      |   |   |
|---|---------|------------------------------|--|---|------|--|------|---|---|
| <div>14897</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>14906</div>  |         |                              |  |   |      |  |      |   |   |
| 1. DECEASED-NAME<br>(Type or Print)   |         |                              | First Middle Last  |   |      | 2a. DATE KNOWN OF DEATH  |      |   | 2b. HOUR                                      |
| Francis Cleveland Kolbe   |         |                              |  |   |      | <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year<br><input checked="" type="checkbox"/> 10-31-68 193:00pm |      |   | 00pm  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR   |      | IF UNDER 24 HRS  |      | 2c. DATE PRONOUNCED DEAD  |   |
| Male  | White   | 11-23-1893                   | 75 YRS.  | MONTHS  | DAYS | HOURS  | MIN. | Month Day Year  | 2d. HOUR                                      |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. COUNTY OF DEATH   |      |   |   |
| Penna.  |         | U. S. A.                     |  |   |      | Prince George's  |      | Md.   |   |
| 10. CITY OR TOWN OF DEATH   |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)                         |   |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |      |   | 12b. KIND OF BUSINESS OR INDUSTRY             |
| Cheverly  |         |                              | Prince George Hospital   |   |      | Tobacco Farmer   |      |   | Own Farm                                      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                              | 13b. COUNTY  |   |      | 13c. CITY OR TOWN  |      | 13d. INSIDE CITY LIMITS?  |   |
| Maryland  |         |                              | Prince George's  |   |      | Upper Marlboro   |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME   |         |                              | 15. MOTHER'S MAIDEN NAME   |   |      | 13e. STREET AND NUMBER   |      |   |   |
| First Middle Last   |         |                              | First Middle Last  |   |      | 7000 Woodyard Road   |      |   |   |
| Philip Wm. Kolbe  |         |                              | Clara -- Schaffer  |   |      |  |      |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         |                              | 16b. SOCIAL SECURITY NO.   |   |      | 17. INFORMANT  |      |   |   |
| Unknown --  |         |                              |  |   |      | Bertha Elizabeth Kolbe-13-e-c.   |      |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Gun shot wound of head<br>955X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |         |                              |  |   |      |  |      |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>976X  |         |                              |  |   |      |  |      |   |   |
| 19a. DATE OF OPERATION  |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |      | 20. AUTOPSY?   |      |   |   |
|   |         |                              |  |   |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |      |   |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |         |                              | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>3:00pm 10-31- 19 68                             |   |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Shot self with .12 gauge shot gun.                              |      |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>Barn in rear of home |   |      | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>same as #13  |      |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |   |      |  |      |   |   |
| ACTUAL SIGNATURE  |         |                              | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |      | 22b. DATE SIGNED   |      |   |   |
| EXAMINER'S NAME (Type)  |         |                              | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |      | 11-1-68  |      |   |   |
| John Kehoe MD Riverdale, Md.  |         |                              | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |      | ADDRESS(Street, city, town, or county)   |      |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |                              | 23b. DATE  |   |      | 23c. NAME OF CEMETERY OR CREMATORY   |      |   | 23d. LOCATION (City or Town) (County) (State) |
| Burial  |         |                              | 11/5/68  |   |      | Epiphany Cemetery  |      |   | Forestville Pr. Geo. Md.                      |
| 24. FUNERAL DIRECTOR  |         |                              |  |   |      | 25a. REC'D BY REGISTRAR  |      | 25b. REGISTRAR'S SIGNATURE  |   |
| Ritchie Bros. Upper Marlboro, Md.   |         |                              |  |   |      | NOV 12 1968  |      | J Charles Judge   |   |



14806

RECORDS SECTION, U.S. DEPT. OF JUSTICE

100-100000

NOV 12 1963

Cleveland Ohio

TO: SAC, CLEVELAND

FROM: SAC, CLEVELAND

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THRU: [Illegible]

INFO: [Illegible]

ATTN: [Illegible]

FILE: [Illegible]

NOTES: [Illegible]

REFERENCE: [Illegible]

COMMENTS: [Illegible]

ACTION: [Illegible]

STATUS: [Illegible]

APPROVAL: [Illegible]

SIGNATURE: [Illegible]

TELETYPE: [Illegible]

TELEPHONE: [Illegible]

MAIL ROOM: [Illegible]

RECEIVED

NOV 12 1963

U.S. DEPT. OF JUSTICE

NOV 12 1963



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14898

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14907

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>PETER</b> <b>WALTER</b> <b>LARSON</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>10</b> Day <b>13</b> Year <b>68</b>            |   |  | 2b. HOUR<br>M   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br><b>12-19-1894</b>   |  | 6. AGE (In years<br>last birthday)<br><b>73</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Michigan</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Prince George</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Captain's Cove</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>9214 Reed Lane</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Auto. Mechanic</b>   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Md.</b>  |  | 13b. COUNTY <b>Pr. Geo.</b>   |  | 13c. CITY OR TOWN<br><b>Captain's Cove</b>  |  | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  | 13e. STREET AND NUMBER<br><b>9214 Reed Lane</b>                  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Peter</b> <b>Larson</b>  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Victoria Carlson Larson</b> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>370-05-5103</b>  |  | 17. INFORMANT Address<br><b>Lulu M. Larson 9214 Reed Lane</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Circumstances of Stomach &amp; Intestines</b><br><b>1519</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3-67-10-68</b> |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>1518</b>  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                     |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory,<br>office building, etc.)                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-13-68</b> to <b>Oct-13-68</b> , that (I) (we) last saw the deceased alive on <b>10-13-68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Herbert Wisotsky</b>  |  | 22c. DATE SIGNED<br><b>10-14-68</b>   |  | 22d. PHYSICIAN'S NAME (Type)<br><b>HERBERT WISOTSKY</b>   |  |   |  | 22e. ADDRESS<br><b>101 Audubon Lane, Oxon Hill</b>               |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>10-16-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Suitland Pr. Geo. Md.</b>                   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Wilhelm Funeral Home 4308 Suitland Rd. S. E.</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 17 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |

70241

UNITED STATES DEPARTMENT OF AGRICULTURE

2107



4



70241-1-1730

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14908

14899

CERTIFICATE OF DEATH

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Frederick Lee</b>  |  | First Middle Last   |  | 2a. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>5</b> Year <b>1968</b>  |  | 2b. HOUR<br><b>6.30 PM</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b> <del>White</del> <b>Negro</b>   |  | 5. DATE OF BIRTH<br><b>March 26, 1880</b>   |  | 6. AGE (In years last birthday)<br><b>88</b> YRS.                                    |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Prince Georges</b> Md.                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Chesverly</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince Georges Gen Hosp.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired Soldier</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Pr. Geo.</b>  |  | 13c. CITY OR TOWN<br><b>Palmer Park</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br><b>Isaac Lee</b>  |  | First Middle Last   |  | 15. MOTHER'S MAIDEN NAME<br><b>Charity Mason</b>  |  | First Middle Last  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>Joseph Lee-uncle-806 Crittenden St., NW</b> Address   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Embolism</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Atherosclerotic Coronal Vasculature Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Congestive Heart Failure</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b><br><b>years</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                    |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that <del>(I)</del> (this hospital) attended the deceased from <b>Sept. 21, 1968</b> , to <b>Oct. 5, 1968</b> , that <del>(I)</del> (we) last saw the deceased alive on <b>10-5-68</b> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(I)</del> (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Law</b>   |  |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>10-6-68</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DR. LAWRENCE S. HARKYAN</b>   |  |   |  | 22e. ADDRESS<br><b>Prince George's Gen'l Hosp. Chesverly, Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/9/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lincoln Memorial Ceme.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Maryland</b>                     |  |
| 24. FUNERAL DIRECTOR<br><b>Stewart</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>N.E. OCT 9 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                   |  |

DEPT. OF SOC. & HUM. SCI.

001

attached.

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1010

2007 2008

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Primo George Van Houten, Jr. (1900-1970)

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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

162

12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|--|--|---|
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |   |
| 1. DECEASED-NAME (Type or print) <b>ROBERT D MAHONEY</b>   |  |  |  |  | 2a. DATE OF DEATH Month <b>10</b> Day <b>7</b> Year <b>1968</b> 2b. HOUR <b>5:30</b> PM  |  |  |  |   |
| 3. SEX <b>M</b>  |  | 4. RACE <b>W</b>   |  | 5. DATE OF BIRTH <b>MAY 16, 1913</b>   |  |  | 6. AGE (In years last birthday) <b>55</b> YRS.                       |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) <b>WASHINGTON</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Pr Geo</b> Md.   |  |  |   |
| 10. CITY OR TOWN OF DEATH <b>Chesley Md</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pr Geo Gen</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Coppersmith</b>                                       |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. N.Y.</b> |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |  | 13b. COUNTY <b>PRINCE GEO.</b>   |  | 13c. CITY OR TOWN <b>BELTSVILLE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <b>11604 CEDAR LN.</b>      |   |
| 14. FATHER'S NAME First Middle Last <b>ROBERT E. MAHONEY</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY PROSSER</b>   |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO. <b>579-48-6716</b>  |  | 17. INFORMANT <b>Hilda Mahoney</b>   |  |  | 17b. ADDRESS <b>BELTSVILLE Md 433-7469</b>                           |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ac Myocardial Failure</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary Atherosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>4200 Diabetes Mellitus</b>   |  |  |  |  |  |  |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>                                    |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |  |  |  |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                   |  | 21f. LOCATION Street or R.F.D. No. <b>1967</b>   |  | City or Town <b>Oct</b>  |  | County <b>68</b>                                   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-6-68</b> , 19 <b>68</b> , to <b>Oct 7</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-6-68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |   |
| 22b. SIGNATURE <b>W.C. Etienne</b>   |  |  |  |  | DEGREE <b>MD</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED <b>10-7-68</b>                                      |  |   |
| 22d. PHYSICIAN'S NAME (Type) <b>W.C. ETIENNE</b>   |  | 22e. ADDRESS <b>College Park Md</b>  |  |  |  |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 23b. DATE <b>10/10/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>GEORGE WASHINGTON</b>  |  | 23d. LOCATION (City or Town) <b>ADELPHI</b>  |  | (County) <b>Md.</b> (State)                        |   |
| 24. FUNERAL DIRECTOR <b>F. GASCH'S SONS - Hyattsville, Md.</b>   |  |  |  |  | 25a. REC'D BY REGISTRAR <b>OCT 11 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                      |  |   |

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Dr. Geo. H. H.

Chas. H. H.

1915-1916  
1917-1918

On the occasion of the  
celebration of the  
centennial of the  
birth of George Washington

President Washington

10-0 to 1907  
out of 08

10-0 to 1907  
1915-1916  
1917-1918

W.C. ELLIOTT  
1915-1916

1915-1916  
1917-1918  
1919-1920



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA AT 151  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |  |  |   |  |   |                                |  |
|---|--|---|--|---|--|--|--|---|--|---|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |  |  |   |  |   |                                |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  |   |                                |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Charles F. MARKEY</i>  |  |   | 2a. DATE OF DEATH<br>Month <i>Oct</i> Day <i>23</i> Year <i>1968</i>   |   |  | 2b. HOUR<br><i>9:15 A M</i>  |  |   |  |   |                                |  |
| 3. SEX<br><i>MALE</i>   |  | 4. RACE<br><i>White</i>                       |  | 5. DATE OF BIRTH<br><i>MAY 1, 1875</i>  |  |  | 6. AGE (In years<br>lost birthday)<br><i>93</i> YRS. |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                      |   | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <i>Virginia</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Prince George Co.</i> Md.   |  |   |  |   |                                |  |
| 10. CITY OR TOWN OF DEATH<br><i>Hyattsville Md.</i>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <i>Hyattsville Nursing Home</i>                          |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) <i>Electric Type Finisher</i> |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |   |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <i>WASH. D.C.</i>  |  |   |  | 13b. COUNTY<br><i>-</i>   |  | 13c. CITY OR TOWN<br><i>WASH. D.C.</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>2115 Monroe St. N.E.</i>   |                                |  |
| 14. FATHER'S NAME First Middle Last<br><i>NARRY MARKEY</i>  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>MARY URN</i>  |   |  |  |  |   |  |   |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  |   | 16b. SOCIAL SECURITY NO.<br><i>578-24-5758</i>   |   |  | 17. INFORMANT<br><i>William E. -son</i>  |  |   | Address<br><i>10405 Hutting Pl., S.S., Md.</i>                                 |   |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i><br><i>4369</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) <i>Cerebral Vascular Accident</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Generalized atherosclerosis</i> |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>mins.</i><br><i>days</i><br><i>years.</i> |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>331X</i>   |  |   |  |   |  |  |  |   |  |   |                                |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?        |   |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |   |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |   |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Dec</i> , 1967, to <i>Oct 23</i> , 1968, that (I) (we) last<br>saw the deceased alive on <i>10/18</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |   |                                |  |
| 22b. SIGNATURE<br><i>Harold W. Draper M.D.</i> DEGREE <i>M.D.</i>   |  |   | ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><i>10/23/68</i>  |  |   |  |   |                                |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <i>HAROLD W. DRAPER, M.D.</i>   |  |   | 22e. ADDRESS<br><i>9801 GEORGIA AVE. SILVER SPRING, MD.</i>  |   |  |  |  |   |  |   |                                |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><i>Burial</i>   |  |   | 23b. DATE<br><i>10-26-1968</i>   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Fort Lincoln Cemetery</i>   |  |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Colmar Manor, Maryland</i> |   |                                |  |
| 24. FUNERAL DIRECTOR<br><i>Lee Funeral Home</i>   |  |   | 25a. REC'D BY REGISTRAR<br><i>300 4th St. N.E. Washington D.C.</i>   |   |  | DATE<br><i>OCT 28 1968</i>   |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                             |   |                                |  |

MEDICAL CERTIFICATION

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14902

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

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|   |         |                              |  |   |                                    |  |      |   |                                   |                                   |  |  |  |  |
|---|---------|------------------------------|--|---|------------------------------------|--|------|---|-----------------------------------|-----------------------------------|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)   |         |                              | First Middle Last  |   |                                    | 2a. DATE KNOWN OF DEATH  |      |   |                                   | 2b. HOUR                          |  |  |  |  |
| Frederick S Martin  |         |                              |  |   |                                    | Month Day Year   |      |   |                                   | 10-12-68 11:00am                  |  |  |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (in years last birthday)  | IF UNDER 1 YEAR   |                                    | IF UNDER 24 HRS.   |      | 2c. DATE PRONOUNCED DEAD                      |                                   |                                   |  | 2d. HOUR                                     |  |  |
| Male  | White   | 2-14-1906                    | 62 YRS.  | MONTHS  | DAYS                               | HOURS  | MIN. | Month Day Year                                |                                   |                                   |  | 10 12 68 1:27pm M                            |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH   |      |   |                                   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |  |
| Rhode Island  |         | U S A                        |  |   |                                    | Prince George's Md.  |      |   |                                   | Forrester - Agricul. U S Gov.     |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)         |   |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)              |      |   | 12b. KIND OF BUSINESS OR INDUSTRY |                                   |  |  |  |  |
| Bowie   |         |                              | 12221 Marne Lane   |   |                                    | Forrester - Agricul.   |      |   | U S Gov.                          |                                   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                              | 13b. CITY OR TOWN  |   |                                    | 13c. INSIDE CITY LIMITS?   |      | 13e. STREET AND NUMBER                        |                                   |                                   |  |  |  |  |
| Maryland  |         |                              | Prince George's Bowie  |   |                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>   |      | 12221 Marne Lane                              |                                   |                                   |  |  |  |  |
| 14. FATHER'S NAME First Middle Last   |         |                              | 15. MOTHER'S MAIDEN NAME First Middle Last   |   |                                    |  |      |   |                                   |                                   |  |  |  |  |
| Frederic Martin   |         |                              | Julia R. Whyte   |   |                                    |  |      |   |                                   |                                   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |                              | 16b. SOCIAL SECURITY NO.   |   |                                    | 17. INFORMANT  |      |   | ADDRESS                           |                                   |  |  |  |  |
| No  |         |                              |  |   |                                    | Eileen S. Martin   |      |   | Bowie, Md. 12221 Marne Lane       |                                   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 955X Gun shot wound of chest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |         |                              |  |   |                                    |  |      |   |                                   |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)<br>976X   |         |                              |  |   |                                    |  |      |   |                                   |                                   |  |  |  |  |
| 19a. DATE OF OPERATION  |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                    |   |                                    | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |      |   |                                   |                                   |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |         |                              | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>11:00am 10-12-68                |   |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Shot self at home |      |   |                                   |                                   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>home |   |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>Same as #13                          |      |   |                                   |                                   |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |                              |  |   |                                    |  |      |   |                                   |                                   |  |  |  |  |
| ACTUAL SIGNATURE  |         |                              | EXAMINER'S NAME (Type)   |   |                                    | 22b. DATE SIGNED   |      |   |                                   |                                   |  |  |  |  |
| John Kehoe MD   |         |                              | Riverdale, Md.   |   |                                    | 10-13-68   |      |   |                                   |                                   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |  |      | 23d. LOCATION (City or Town) (County) (State) |                                   |                                   |  |  |  |  |
| Burial  |         |                              | 10-16-68   |   | Rawlings Cemetery                  |  |      | Athens Ohio                                   |                                   |                                   |  |  |  |  |
| 24. FUNERAL DIRECTOR  |         |                              | ADDRESS  |   |                                    | 25a. REC'D BY REGISTRAR  |      |   | 25b. REGISTRAR'S SIGNATURE        |                                   |  |  |  |  |
| Wilhelm Funeral Home  |         |                              | 4308 Suitland Rd. S. E.  |   |                                    | OCT 17 1968  |      |   | Charles Judge                     |                                   |  |  |  |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14903

14912

|  |         |                  |   |                                |  |   |  |   |  |  |          |
|--|---------|------------------|---|--------------------------------|--|---|--|---|--|--|----------|
| 1. DECEASED-NAME<br>(Type or Print)  |         |                  | First Middle Last   |                                |  | 2a. DATE KNOWN<br>OF<br>DEATH MATED <input checked="" type="checkbox"/> 10-7-68 19 12:20pm  |  |   | 2b. HOUR   |  |          |
| Gertrude   |         |                  | S   |                                |  | Mathews   |  |   |  |  |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years<br>last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>Month 10 Day 7 Year 68 19 12:35pm |  |  | 2d. HOUR |
| Female   | Negro   | 3-27-1900        | 68 YRS.   |                                |  |   |  |   |  |  |          |
| 7a. BIRTHPLACE (State or foreign<br>country)   |         |                  | 7b. CITIZEN OF WHAT COUNTRY?  |                                |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH<br>Prince George's Md.  |  |          |
| HOWARD CO. MD  |         |                  | U.S.A.  |                                |  |   |  |   |  |  |          |
| 10. CITY OR TOWN OF DEATH  |         |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |                                |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |          |
| Cheverly   |         |                  | Prince George Hospital  |                                |  |   |  |   |  |  |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) - STATE   |         |                  | 13b. COUNTY   |                                |  | 13c. CITY OR TOWN   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |
| Maryland   |         |                  | P.C.  |                                |  | Laurel  |  |   | 502 9th. Street  |  |          |
| 14. FATHER'S NAME  |         |                  | 15. MOTHER'S MAIDEN NAME  |                                |  |   |  |   |  |  |          |
| First Middle Last  |         |                  | First Middle Last   |                                |  |   |  |   |  |  |          |
| EDWARD   |         |                  | BROOKS  |                                |  | KATHERINE   |  |   | HOWARD   |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |         |                  | 16b. SOCIAL SECURITY NO.<br>(If give war or dates of service)                   |                                |  | 17. INFORMANT   |  |   | ADDRESS  |  |          |
|  |         |                  |   |                                |  | MRS CATHERINE BURLEY  |  |   | LAUREL, MD   |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____  |         |                  |   |                                |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>minutes<br>unknown                |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>4200</u>   |         |                  |   |                                |  |   |  |   |  |  |          |
| 19a. DATE OF OPERATION   |         |                  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                            |                                |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |          |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |         |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19                       |                                |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         |                  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |                                |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |                  |   |                                |  |   |  |   |  |  |          |
| ACTUAL<br>SIGNATURE  |         |                  | M.D.  |                                |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   | 22b. DATE SIGNED   |  |          |
| EXAMINER'S<br>NAME (Type)  |         |                  | John Kehoe MD Riverdale, Md.  |                                |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   | 10-8-68  |  |          |
|  |         |                  |   |                                |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   | ADDRESS (Street, city, town, or county)  |  |          |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |         |                  | 23b. DATE   |                                |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   | 23d. LOCATION (City or Town) (County) (State)  |  |          |
| BURIAL   |         |                  | 10-11-68  |                                |  | QUEENS CHAPEL CEM.  |  |   | MURKIRK, PR GRGS MD  |  |          |
| 24. FUNERAL DIRECTOR   |         |                  | ADDRESS   |                                |  | 25a. REC'D BY REGISTRAR   |  |   | 25b. REGISTRAR'S SIGNATURE   |  |          |
| Robert L. Snowden  |         |                  | Rockville, Md   |                                |  | OCT 14 1968   |  |   | [Signature]  |  |          |

14812

WORLD EXHIBITION CERTIFICATE OF DEATH

1900

HEALTH OFFICE



|             |  |             |  |                    |  |                 |  |                 |  |                |  |                |  |               |  |                        |  |                        |  |                      |  |                 |  |                 |  |                |  |                        |  |                        |  |                        |  |
|-------------|--|-------------|--|--------------------|--|-----------------|--|-----------------|--|----------------|--|----------------|--|---------------|--|------------------------|--|------------------------|--|----------------------|--|-----------------|--|-----------------|--|----------------|--|------------------------|--|------------------------|--|------------------------|--|
| Name        |  | Age         |  | Sex                |  | Race            |  | Religion        |  | Marital Status |  | Occupation     |  | Education     |  | Previous Residence     |  | Date of Birth          |  | Date of Death        |  | Cause of Death  |  | Place of Death  |  | Time of Death  |  | Signature of Physician |  | Signature of Registrar |  | Signature of Witness   |  |
| John Doe    |  | 35          |  | Male               |  | White           |  | Protestant      |  | Single         |  | Teacher        |  | High School   |  | New York City          |  | January 1, 1900        |  | January 1, 1900      |  | Heart Disease   |  | New York City   |  | 10:00 AM       |  | John Doe, M.D.         |  | John Doe, M.D.         |  | John Doe, M.D.         |  |
| Address     |  | City        |  | State              |  | Country         |  | County          |  | Township       |  | Village        |  | Ward          |  | Precinct               |  | Block                  |  | Lot                  |  | House           |  | Apartment       |  | Room           |  | Floor                  |  | Cellar                 |  | Basement               |  |
| 123 Main St |  | New York    |  | NY                 |  | USA             |  | New York        |  | Manhattan      |  | Central        |  | East          |  | 1st                    |  | 100                    |  | 100                  |  | 100             |  | 100             |  | 100            |  | 100                    |  | 100                    |  | 100                    |  |
| Occupation  |  | Education   |  | Previous Residence |  | Date of Birth   |  | Date of Death   |  | Cause of Death |  | Place of Death |  | Time of Death |  | Signature of Physician |  | Signature of Registrar |  | Signature of Witness |  | Date of Birth   |  | Date of Death   |  | Cause of Death |  | Place of Death         |  | Time of Death          |  | Signature of Physician |  |
| Teacher     |  | High School |  | New York City      |  | January 1, 1900 |  | January 1, 1900 |  | Heart Disease  |  | New York City  |  | 10:00 AM      |  | John Doe, M.D.         |  | John Doe, M.D.         |  | John Doe, M.D.       |  | January 1, 1900 |  | January 1, 1900 |  | Heart Disease  |  | New York City          |  | 10:00 AM               |  | John Doe, M.D.         |  |

Oct 1 1900



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14904

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item#5&6, FilmG406

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14913

|  |                         |  |   |   |   |   |  |  |
|--|-------------------------|--|---|---|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print)<br>First Middle Last<br><b>Edward L McCormack</b>  |                         |  | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br><b>10-26-68</b>  |   |   | 2b. HOUR<br>19 11:30am  |  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>11-30-1911</b>        | 6. AGE (in years last birthday)<br><b>57 56 YRS.</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>54 56</b>  | IF UNDER 24 HRS.<br>HOURS MIN<br><b>54 56</b> | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>10 26 68</b>   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Va</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b> |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince George Hospital</b>   |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired machinist</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U S Government</b>                           |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |                         |  | 13b. COUNTY<br><b>Prince George's</b>   |   |   | 13c. CITY OR TOWN<br><b>Hyattsville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Edward Mc Cormack</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Mae Beasley</b>   |   |   | 13e. STREET AND NUMBER<br><b>6722 Fairwood Road</b>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>no</b>   |                         |  | 16b. SOCIAL SECURITY NO.<br><b>212 07 2658</b>  |   |   | 17. INFORMANT<br><b>Ruth E Mc Cormack</b>   |  |  |
|  |                         |  | ADDRESS<br><b>Hyattsville, Md.</b>  |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Occlusion of coronary artery</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic heart disease</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>4129</b>         |                         |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes over 9 yrs</b>            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4201</b>   |                         |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                         |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br><b>19</b>   |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                     |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                         |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |   |   |   |   |  |  |
| ACTUAL SIGNATURE<br><b>John Kehoe</b>  |                         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   |   | 22b. DATE SIGNED<br><b>10-27-68</b>   |  |  |
| EXAMINER'S NAME (Type)<br><b>John Kehoe MD</b>   |                         |  | ADDRESS<br><b>Riverdale, Md.</b>  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         |  | 23b. DATE<br><b>Oct 29, 1968</b>  |   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln Cemetery</b>  |  |  |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b>   |                         |  | ADDRESS<br><b>Hyattsville, Md.</b>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Colmar Manor Pro Geo Md.</b>                                    |  |  |
| 25a. REC'D BY REGISTRAR<br><b>OCT 31 1968</b>  |                         |  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14905

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14914

|  |  |  |   |  |  |   |  |  |   |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last<br>Richard J McGarry  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br>Oct. 8, 1968   |  |  | 2b. HOUR<br>8 P.M.  |  |  |
| 3. SEX<br>Male   |  |  | 4. RACE<br>Caucasian  |  |  | 5. DATE OF BIRTH<br>3/4/15  |  |  | 6. AGE (In years last birthday)<br>53 YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>New Jersey  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Prince George's Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Cheverly  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Prince Geo.Gen'l Hospital |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Presser  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>cloths   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>New Jersey  |  |  | 13b. COUNTY<br>Paterson   |  |  | 13c. CITY OR TOWN<br>Paterson   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br>31A Alabama Avenue   |  |  | 14. FATHER'S NAME<br>First Middle Last<br>Thomas Mc Garry   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Rose Kelley  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>Yes   |  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>W W 11                               |  |  | 17. INFORMANT<br>Regina McGarry   |  |  | Address<br>Paterson N. J.   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>485X</u> Bilateral Bronchial Pneumonia, acute, with abscess formation.<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>491X</u>  |  |  |   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>Yes                     |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |
| 22a. I certify that (we) (this hospital) attended the deceased from <u>Sept. 2, 1968</u> , to <u>Oct. 8, 1968</u> , that <u>we</u> last saw the deceased alive on <u>Oct. 8, 1968</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>we</u> (we) (did not) view the body after death.  |  |  |   |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>V. Charles</u>  |  |  |   |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |  |  | 22c. DATE SIGNED<br>Oct. 9, 1968  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>V. Charles, M. D.  |  |  |   |  |  | 22e. ADDRESS<br>Prince George's General Hospital, Cheverly, Maryland  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>Oct 12, 1968   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Sepulchre Cemetery   |  |  | 23d. LOCATION (City or Town) (County) State<br>Totowa-Boro Passais N J.                         |  |  |
| 24. FUNERAL DIRECTOR<br>F. Gasch's Sons  |  |  |   |  |  | ADDRESS<br>Hyattsville, Md.   |  |  | 25a. REC'D BY REGISTRAR<br>DATE OCT 14 1968   |  |  |
|  |  |  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>   |  |  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| <div style="display: flex; justify-content: space-between;"> <span>14906</span> <span>CERTIFICATE OF DEATH</span> <span>14915</span> </div>   |  |  |  |  |  |  |  |   |  |
| 1. DECEASED-NAME (Type or print) <b>Kathleen Baby Marie Girl "A" McGehee Twin I</b>   |  |  |  |  | 2a. DATE OF DEATH<br><b>Oct. Month 9, Day 1968</b>   |  | 2b. HOUR<br><b>7:50PM</b>  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br><b>Oct. 9, 1968</b>  |  | 6. AGE (In years last birthday)<br><b>YRS.</b>                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br><b>30</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Prince George's Md.</b>                                     |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince Geo.Gen'l Hospital</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Prince George's</b>  |  | 13c. CITY OR TOWN<br><b>Hyattsville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>6611 24th Place</b>      |  |
| 14. FATHER'S NAME First Middle Last<br><b>Milton Manuel McGehee</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Linda Anne Fowler</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>777X mortified prenatally</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                           |  |  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>776X</b>   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                     |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |  |
| 22a. I certify that (I) <del>(we)</del> attended the deceased from <b>Oct. 9, 1968</b> , to <b>Oct. 9, 1968</b> , that (I) <del>(we)</del> saw the deceased (alive) on <b>Oct. 9, 1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(didn't)</del> view the body after death. |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Radji Mahadavi, M. D.</b>  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Oct. 11, 1968</b>                             |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Radji Mahadavi, M. D.</b>  |  |  |  |  | 22e. ADDRESS<br><b>6821 Riverdale Rd., Riverdale, Md. 20840</b>  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>10/26/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Prince Geo. General Hospital</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cheverly, Maryland</b>           |  |   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>William A. Parker, Assoc. Administrator</b>  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 29 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-64

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |  |   |   |  |                                   |  |  |
|--|--|---|--|--|---|---|--|-----------------------------------|--|--|
| CERTIFICATE OF DEATH   |  |   |  |  |   |   |  |                                   |  |  |
| 1. DECEASED-NAME (Type or print) <b>Virconia Lynn Baby/Girl/B" McGehee Twin II</b>   |  |   |  |  | 2a. DATE OF DEATH Month <b>Oct.</b> Day <b>9,</b> Year <b>1968</b>                      |   |  | 2b. HOUR <b>8:20PM</b>            |  |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>Caucasian</b>  |  | 5. DATE OF BIRTH <b>Oct. 9, 1968</b>   |   |   | 6. AGE (In years last birthday) <b>1</b> YRS.                        |                                   | IF UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>1</b> IF UNDER 24 HRS. HOURS <b>1</b> MIN. |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>US..A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>Prince George's Md.</b>                           |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH <b>Cheverly</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo.Gen'l HOSpital</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  | 13b. CITY OR TOWN <b>Prince George's</b>  |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 13d. STREET AND NUMBER <b>6611 24th Place</b>                           |  |                                   |  |  |
| 14. FATHER'S NAME First <b>Milton Manuel McGehee</b> Middle <b>McGehee</b> Last <b>McGehee</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME First <b>Linda Anne Fowler</b> Middle <b>Fowler</b> Last <b>Fowler</b>  |   |   |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address  |   |   |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Marked prematurity</b><br><b>777X</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>777X</b> DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>777X</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>776X</b> |  |   |  |  |   |   |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |                                   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |                                   |  |  |
| 22a. I certify that (I) <b>(at this hospital)</b> attended the deceased from <b>Oct. 9,</b> 19 <b>68</b> , to <b>Oct. 8,</b> 19 <b>68</b> , that (I) <b>(saw)</b> lost saw the deceased alive on <b>Oct. 9,</b> 19 <b>68</b> , and that in (my) <b>(my)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(saw)</b> (did) (did not) view the body after death.  |  |   |  |  |   |   |  |                                   |  |  |
| 22b. SIGNATURE <b>Iradi Mahadavi, M. D.</b>  |  |   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |   | 22c. DATE SIGNED <b>Oct. 11, 1968</b>                                   |  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Iradi Mahadavi, M. D.</b>  |  |   |  | 22e. ADDRESS <b>6821 Riverdale Rd., Riverdale, Md. 20840</b>   |   |   |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE <b>10/26/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. General Hosp.</b>  |   | 23d. LOCATION (City or Town) (County) (State) <b>Cheverly, Maryland</b> |  |                                   |  |  |
| 24. FUNERAL DIRECTOR <b>William A. Parker, Assoc. Administrator</b>  |  |   |  | 25a. REC'D BY REGISTRAR <b>OCT 29 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                         |  |                                   |  |  |

81-28265

TO: DIRECTOR, FBI (100-374310) FROM: SAC, NEW YORK (100-100000) (P)

RE: JAMES EARL RAY, AKA; ALLEGEDLY FUGITIVE;  
MURDER OF MARTIN LUTHER KING, JR.;  
BIRMINGHAM, ALABAMA, APRIL 4, 1968;  
FEDERAL BUREAU OF INVESTIGATION  
NEW YORK OFFICE

DATE: OCTOBER 10, 1968

RE: NEW YORK TELETYPE TO BUREAU, OCTOBER 9, 1968.

ENCLOSED FOR THE BUREAU ARE TWO COPIES OF A  
LETTERHEAD MEMORANDUM DATED AND CAPTIONED AS ABOVE.

ADMINISTRATIVE: NEW YORK OFFICE IS CURRENTLY  
CONDUCTING AN INVESTIGATION OF THE MATTER.

ADMINISTRATIVE: NEW YORK OFFICE IS CURRENTLY  
CONDUCTING AN INVESTIGATION OF THE MATTER.

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ADMINISTRATIVE: NEW YORK OFFICE IS CURRENTLY  
CONDUCTING AN INVESTIGATION OF THE MATTER.

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-9. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14908

## MARYLAND STATE HOSPITAL OF DEATH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14917

|  |                         |   |  |   |  |  |  |  |
|--|-------------------------|---|--|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>George M McSweeney</b>  |                         |   | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 10-22-68 19 4:45pm |   |  | 2b. HOUR   |  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>2-25-1912</b>  | 6. AGE (in years last birthday)<br><b>56</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   | IF UNDER 24 HRS  | 2c. DATE PRONOUNCED DEAD<br>Month <b>10</b> Day <b>22</b> Year <b>68</b> 19 8:09pm M |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>ALABAMA</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.                                     |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince George Hospital</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>RETIRED MARINE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DEFENSE DEPT</b> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Prince George's</b>  |                         |   | 13b. CITY OR TOWN<br><b>Bladensburg</b>  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  | 13e. STREET AND NUMBER<br><b>5030 57th. Ave.</b>         |  |
| 14. FATHER'S NAME First Middle Last<br><b>UNKNOWN</b>  |                         |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>UNKNOWN</b>                         |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>YES</b>   |                         |   | 16b. SOCIAL SECURITY NO.<br><b>57718 3958</b>  |   | 17. INFORMANT ADDRESS<br><b>MARGUERITE P. MCSWEENEY MENLO, IOWA,</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes over 3 yrs.</b> |                         |   |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4200</b>   |                         |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                    |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>                           |                         |   |  |   |  |  |  |  |
| ACTUAL SIGNATURE <b>John Kehoe</b> M.D.  |                         |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                      |   |  | 22b. DATE SIGNED <b>10-23-68</b>   |  |  |
| EXAMINER'S NAME (Type) <b>John Kehoe MD Riverdale, Md.</b>   |                         |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                          |  |  |
|  |                         |   | ADDRESS (Street, city, town, or county)  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                         | 23b. DATE<br><b>10-26-1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>STUART CEMETERY</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>STUART IOWA.</b>                 |  |  |
| 24. FUNERAL DIRECTOR<br><b>W.W. CHAMBERS Co. RIVERDALE, MARYLAND</b>   |                         |   | 25a. RECEIVED BY REGISTRAR<br>DATE <b>OCT 28 1968</b>                                |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                   |  |  |

1981

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FOR THE  
FEDERAL BUREAU OF INVESTIGATION



|                      |   |       |         |        |
|----------------------|---|-------|---------|--------|
| NAME                 | LAST  | FIRST | MIDDLE  | SUFFIX |
| SMITH                | JOHN  | DAVID | WILLIAM | JR     |
| DATE OF BIRTH        | 1945  | 03    | 15      |        |
| PLACE OF BIRTH       | NEW YORK, NEW YORK                              |       |         |        |
| CURRENT ADDRESS      | 123 MAIN STREET<br>APT 4B<br>NEW YORK, NY 10001 |       |         |        |
| TELEPHONE            | 212-555-1234                                    |       |         |        |
| EMPLOYER             | ABC COMPANY                                     |       |         |        |
| POSITION             | MANAGER   |       |         |        |
| EDUCATION            | B.S. in Business Administration                 |       |         |        |
| DEGREE               | Bachelor of Science                             |       |         |        |
| UNIVERSITY           | Columbia University                             |       |         |        |
| GRADUATION YEAR      | 1970  |       |         |        |
| PROFESSIONAL LICENSE | None  |       |         |        |
| CRIMINAL RECORD      | None  |       |         |        |
| FINANCIAL RECORD     | None  |       |         |        |
| TRAVEL RECORD        | None  |       |         |        |
| OTHER RECORDS        | None  |       |         |        |

1981 OCT 28 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14909

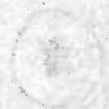
CERTIFICATE OF DEATH

14918

|   |  |   |        |   |                             |   |          |   |
|---|--|---|--------|---|-----------------------------|---|----------|---|
| 1. DECEASED-NAME<br>(Type or print)   |  | First   | Middle | Last  | 2a. DATE OF DEATH           |   | 2b. HOUR |   |
| Robert  |  | H   |        | Melvin sr.  | Month Oct Day 11, Year 1968 |   | M        |   |
| 3. SEX  |  | 4. RACE   |        | 5. DATE OF BIRTH  |                             | 6. AGE (In years<br>last birthday)  |          | IF UNDER 1 YEAR<br>MONTHS DAYS                  |
| male  |  | white   |        | April 16, 1891  |                             | 77 YRS.   |          | IF UNDER 24 HRS.<br>HOURS MIN.                  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. COUNTY OF DEATH  |          |   |
| North carolina  |  | U S A   |        |   |                             | Prince George's Md.   |          |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |        | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |                             | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |          |   |
| Cheverly  |  | Prince George's Hospital  |        | Auto Dealer   |                             | Automobiles   |          |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |  | 13b. COUNTY   |        | 13c. CITY OR TOWN   |                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          | 13e. STREET AND NUMBER                          |
| Md  |  | Pro George's  |        | Bladensburg   |                             |   |          | 4200 53 Place Apt #1                            |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |        | Address   |                             |   |          |   |
| First Middle Last   |  | First Middle Last   |        |   |                             |   |          |   |
| Daniel H Melvin   |  | Martha E Furmidge   |        |   |                             |   |          |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  | 16b. SOCIAL SECURITY NO.  |        | 17. INFORMANT   |                             |   |          |   |
| no  |  | 578 01 5256   |        | Lillian H. Melvin Bladensburg, Md.  |                             |   |          |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARCINOMA of PANCREAS</u><br><u>1579</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. <u>157x</u><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |        |   |                             |   |          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><u>Arteriosclerotic Heart Disease</u>   |  |   |        |   |                             |   |          |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |        | 20a. AUTOPSY?   |                             | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |          |   |
| 10-10-68  |  | CARCINOMA of PANCREAS   |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                             |   |          |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                             |   |          |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                             |   |          |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-2</u> , 19 <u>68</u> , to <u>10-12</u> , 19 <u>68</u> , that (I) (we) last<br>saw the deceased alive on <u>10-11</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |   |        |   |                             |   |          |   |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED  |        | 22d. ADDRESS  |                             |   |          |   |
| <u>A. Deitz</u>   |  | <u>10-12-68</u>   |        | <u>Pro Geo Plaza Hyattsville, Md.</u>   |                             |   |          |   |
| 22d. PHYSICIAN'S<br>NAME (Type)   |  | 22e. ADDRESS  |        | 22f. REC'D BY REGISTRAR   |                             |   |          |   |
| <u>A Deitz</u>  |  | <u>Pro Geo Plaza Hyattsville, Md.</u>   |        | <u>OCT 14 1968</u>  |                             |   |          |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE   |        | 23c. NAME OF CEMETERY OR <del>CREMATOR</del>  |                             | 23d. LOCATION (City or Town) (County) (State)   |          |   |
| Burial  |  | Oct 15, 1968  |        | Friendship Methodist church   |                             | Friendship Calvert Md   |          |   |
| 24. FUNERAL DIRECTOR  |  | 25a. REC'D BY REGISTRAR   |        | 25b. REGISTRAR'S SIGNATURE  |                             |   |          |   |
| <u>F. Gasch's Sons</u>  |  | <u>Hyattsville, Md.</u>   |        | <u>Charles Judge</u>  |                             |   |          |   |

14918

RECEIVED





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                              |  |  |                                    |  |  |  |                                   |  |                  |  |
|--|--|------------------------------|--|--|------------------------------------|--|--|--|-----------------------------------|--|------------------|--|
| 14910  |  |                              |  |  |                                    | 14919  |  |  |                                   |  |                  |  |
| 1. DECEASED-NAME (Type or print)   |  |                              |  |  |                                    | 2a. DATE OF DEATH  |  |  | 2b. HOUR                          |  |                  |  |
| HELEN MAE MERSON   |  |                              |  |  |                                    | Oct 31 1968  |  |  | M                                 |  |                  |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH   |                                    |  | 6. AGE (In years lost birthday)  |  | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS. |  |
| F  |  | W                            |  | March 23 1906  |                                    |  | 62 YRS.  |  | MONTHS DAYS                       |  | HOURS MIN.       |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH   |  |  |                                   |  |                  |  |
| Virginia   |  | USA                          |  |  |                                    | Prince George Md.  |  |  |                                   |  |                  |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                  |  |
| Laurel   |  |                              | 1009 WARD ST   |  |                                    | housewife  |  |  | home                              |  |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER            |  |                  |  |
| Md   |  |                              | PG   |  | Laurel                             |  |  |  | 1009 WARD ST.                     |  |                  |  |
| 14. FATHER'S NAME First Middle Last  |  |                              |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |                                    |  |  |  |                                   |  |                  |  |
| Harace Johnson   |  |                              |  | Lucie Dennis   |                                    |  |  |  |                                   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)   |  |                              |  | 16b. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT  |  |  | Address                           |  |                  |  |
| no   |  |                              |  |  |                                    | Joan Merson  |  |  | Laurel Md                         |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                              |  |  |                                    |  |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction   |  |                              |  |  |                                    |  |  |  |                                   |  |                  |  |
| 2509   |  |                              |  |  |                                    |  |  |  |                                   |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |                              |  |  |                                    |  |  |  |                                   |  |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |                              |  |  |                                    |  |  |  |                                   |  |                  |  |
| (b) Arteriosclerosis   |  |                              |  |  |                                    |  |  |  |                                   |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |                              |  |  |                                    |  |  |  |                                   |  |                  |  |
| (c) Diabetes and Hypo thyroidism   |  |                              |  |  |                                    |  |  |  |                                   |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                              |  |  |                                    |  |  |  |                                   |  |                  |  |
| 260X   |  |                              |  |  |                                    |  |  |  |                                   |  |                  |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |  |                  |  |
|  |  |                              |  |  |                                    |  |  |  |                                   |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)        |  |  |                                   |  |                  |  |
|  |  |                              |  |  |                                    |  |  |  |                                   |  |                  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State                           |  |  |                                   |  |                  |  |
|  |  |                              |  |  |                                    |  |  |  |                                   |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1967, to Oct 1968, that (I) (we) lost saw the deceased alive on Oct 30 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                              |  |  |                                    |  |  |  |                                   |  |                  |  |
| 22b. SIGNATURE   |  |                              |  |  |                                    |  |  |  |                                   | 22c. DATE SIGNED                             |                  |  |
| Arnold J. Brody  |  |                              |  |  |                                    |  |  |  |                                   | 1 Nov 68                                     |                  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |                              |  |  |                                    |  |  |  |                                   | 22e. ADDRESS                                 |                  |  |
| ARNOLD BRODY   |  |                              |  |  |                                    |  |  |  |                                   |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  | 23d. LOCATION (City or Town) (County) (State)                        |                                   |  |                  |  |
| Burial   |  |                              | 11-3-68  |  | Arlington Hill Cem                 |  |  | Laurel Md  |                                   |  |                  |  |
| 24. FUNERAL DIRECTOR   |  |                              |  |  |                                    | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |                                   |  |                  |  |
| Donnelan Funeral Home Laurel Md  |  |                              |  |  |                                    | NOV 8 1968   |  | Charles Judge  |                                   |  |                  |  |

81041

RECEIVED 30 JAN 1954

806 8 VCH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

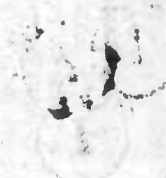
VR A15 (11)  
30M REV. 1-60

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |   |   |   |                        |  |
|---|--|--|--|---|---|---|---|---|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |   |   |   |                        |  |
| CERTIFICATE OF DEATH  |  |  |  |   |   |   |   |   |                        |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |   |   | 2a. DATE OF DEATH   |   | 2b. HOUR  |                        |  |
| James T. Millard  |  |  |  |   |   | Oct. 8, 1968  |   | 4 P.M.  |                        |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years lost birthday)   |   | IF UNDER 1 YEAR<br>MONTHS DAYS                  |                        |  |
| Male  |  | Caucasian  |  | August 19, 1900   |   | 68 YRS.   |   | IF UNDER 24 HRS.<br>HOURS MIN.                  |                        |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   |   |                        |  |
| Maryland  |  | USA  |  |   |   | Prince George's Md.   |   |   |                        |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY               |                        |  |
| Cheverly DOA  |  |  | Prince Geo. Gen'l Hospital   |   |   | carpenter   |   |   |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER |  |
| Maryland  |  |  | Prince George's  |   | Upper Marlboro  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |   | 2209 Sansbury Rd.      |  |
| 14. FATHER'S NAME First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |   |   |   |   |   |                        |  |
|   |  |  |  |   |   |   |   |   |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address   |   |   |   |                        |  |
|   |  |  | 577-30-3533-A  |   | Dewitt T. Gallahan 2209 Stansbury Rd. Upper Marlboro Md.                          |   |   |   |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |   |   |   |   |                        |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |   |   |   |   |                        |  |
| IMMEDIATE CAUSE (a) <u>Acute Cerebellar Infarction.</u>   |  |  |  |   |   |   |   |   |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |   |   |   |   |                        |  |
| (b) <u>Right Bronchopneumonia.</u>  |  |  |  |   |   |   |   |   |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |   |   |   |   |                        |  |
| (c)   |  |  |  |   |   |   |   |   |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |   |   |   |                        |  |
| 332x  |  |  |  |   |   |   |   |   |                        |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes          |   |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |   |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |   |                        |  |
| 22a. I certify that (I) <del>(we)</del> <u>(he)</u> attended the deceased from <u>9-11</u> , 19 <u>68</u> , to <u>Oct. 8</u> , 19 <u>68</u> , that (I) <del>(we)</del> <u>(he)</u> last saw the deceased alive on <u>Oct. 8</u> , 19 <u>68</u> , and that in (my) <del>(our)</del> <u>(my)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <u>(he)</u> <del>(did not)</del> <u>(did)</u> view the body after death. |  |  |  |   |   |   |   |   |                        |  |
| 22b. SIGNATURE <u>Oliver B. Bond</u> M.D. DEGREE <u>MD</u>  |  |  |  |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED <u>Oct. 9, 1968</u>            |                        |  |
| 22d. PHYSICIAN'S NAME (Type) <u>Oliver Bond, M. D.</u>  |  |  |  |   |   | 22e. ADDRESS <u>6872 Riverdale Rd., Lanham, Md. 20801</u>   |   |   |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)   |   |   |                        |  |
|   |  | <u>Oct. 12, 1968</u>   |  | <u>Epiphany</u>   |   | <u>Forestville, P.G.</u> Md.  |   |   |                        |  |
| 24. FUNERAL DIRECTOR ADDRESS <u>Matthewly 131-11th St. S.E.</u>   |  |  |  |   |   | 25a. REC'D BY REGISTRAR DATE <u>OCT 14 1968</u>   |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |                        |  |

19881

19881

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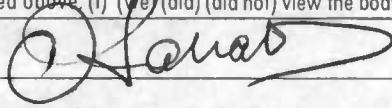
CERTIFICATE OF DEATH

14910

14922

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |           |  |                  |   |                                 |  |                        |  |  |
|--|-----------|--|------------------|---|---------------------------------|--|------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |           | First  | Middle           | Last  | 2a. DATE OF DEATH               |  | 2b. HOUR               |  |  |
| Eunice Catherine Millwood  |           |  |                  |   | Month Day Year<br>Oct. 17, 1968 |  | 1:30 P.M.              |  |  |
| 3. SEX   | 4. RACE   |  | 5. DATE OF BIRTH |   | 6. AGE (In years last birthday) |  | IF UNDER 1 YEAR        |  |  |
| Female   | Caucasian |  | 8/27/07          |   | 61 YRS.                         |  | MONTHS DAYS HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |           | 7b. CITIZEN OF WHAT COUNTRY?   |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9. COUNTY OF DEATH   |                        |  |  |
| South Carolina   |           | U S A  |                  |   |                                 | Prince George's Md.  |                        |  |  |
| 10. CITY OR TOWN OF DEATH  |           | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                        |  |  |
| Cheverly   |           | Prince George's General  |                  | weaver  |                                 | Textile  |                        |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |           | 13b. COUNTY  |                  | 13c. CITY OR TOWN   |                                 | 13d. INSIDE CITY LIMITS?   |                        | 13e. STREET AND NUMBER                       |  |
| Md   |           | Pro Geo  |                  | Hyattsville   |                                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                        | 5511 43rd place                              |  |
| 14. FATHER'S NAME  |           | 15. MOTHER'S MAIDEN NAME   |                  |   |                                 |  |                        |  |  |
| First Middle Last  |           | First Middle Last  |                  |   |                                 |  |                        |  |  |
| ?  |           | Childers   |                  | Nettie Pettie   |                                 |  |                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)   |           | 16b. SOCIAL SECURITY NO.   |                  | 17. INFORMANT Address   |                                 |  |                        |  |  |
| no   |           | 247-07-6290  |                  | Robert J Mead Hyattsville, Md.  |                                 |  |                        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |           |  |                  |   |                                 |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:   |           |  |                  |   |                                 |  |                        |  |  |
| IMMEDIATE CAUSE (a) <u>and Broncho-pneumonia,</u>  |           |  |                  |   |                                 |  |                        |  |  |
| 1621 DUE TO, OR AS A CONSEQUENCE OF <u>Cancer of the right lung with</u>   |           |  |                  |   |                                 |  |                        |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>wide-spread metastasis.</u>  |           |  |                  |   |                                 |  |                        |  |  |
| DUE TO, OR AS A CONSEQUENCE OF <u>Generalized Arteriosclerosis indicated.</u>  |           |  |                  |   |                                 |  |                        |  |  |
| (c) <u>Cachexia.</u>   |           |  |                  |   |                                 |  |                        |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |           |  |                  |   |                                 |  |                        |  |  |
| 163X   |           |  |                  |   |                                 |  |                        |  |  |
| 19a. DATE OF OPERATION   |           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  | 20a. AUTOPSY?   |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                        |  |  |
|  |           |  |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                 |  |                        |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |           | 21b. TIME OF INJURY  |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |                                 |  |                        |  |  |
|  |           | HOUR A.M. Month Day Year P.M. 19   |                  |   |                                 |  |                        |  |  |
| 21d. INJURY OCCURRED   |           | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                 |  |                        |  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |           |  |                  |   |                                 |  |                        |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/26</u> , 19 <u>68</u> , to <u>10/17</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>10/17</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |           |  |                  |   |                                 |  |                        |  |  |
| 22b. SIGNATURE   |           | 22c. DATE SIGNED   |                  |   |                                 |  |                        |  |  |
|   |           |  |                  |   |                                 |  |                        |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |           | 22e. ADDRESS   |                  |   |                                 |  |                        |  |  |
| Dr. Ohannes Sahakyan   |           | 6001 Landover Rd., Cheverly, Md. 20785                                       |                  |   |                                 |  |                        |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |           | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY  |                                 | 23d. LOCATION (City or Town) (County) (State)                        |                        |  |  |
| Burial   |           | Oct 20, 1968.  |                  | Clifton Cemetery  |                                 | Clifton S C  |                        |  |  |
| 24. FUNERAL DIRECTOR   |           | 25a. REC'D BY REGISTRAR  |                  | 25b. REGISTRAR'S SIGNATURE  |                                 |  |                        |  |  |
| F. Gasch's Sons  |           | DATE OCT 21 1968   |                  |    |                                 |  |                        |  |  |
| Hyattsville, Md  |           |  |                  |   |                                 |  |                        |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14913

CERTIFICATE OF DEATH

14923

|   |  |  |  |   |  |   |  |                          |  |  |  |
|---|--|--|--|---|--|---|--|--------------------------|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  | First  |  | Middle  |  | Last  |  | 2a. DATE OF DEATH        |  | 2b. HOUR                                     |  |
| John  |  | Moniz  |  | Oct.  |  | Month 16, Day 1968 Year   |  | 10 A.M.                  |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years lost by day)   |  | IF UNDER 1 YEAR          |  | IF UNDER 24 HRS.                             |  |
| Male  |  | Caucasian  |  | March 8 1914  |  | 34 YRS.   |  | MONTHS DAYS              |  | HOURS MIN                                    |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                          |  |  |  |
| New York  |  | U S A  |  |   |  | Prince George's   |  |                          |  | Md.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                          |  |  |  |
| Cheverly  |  | Prince Geo. Gen'l Hospital   |  | Crain operator  |  | Salvage Co  |  |                          |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |  |  |
| New York  |  | Kings  |  | Brooklyn  |  |   |  | 728 Leffets St.          |  |  |  |
| 14. FATHER'S NAME   |  | First  |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME |  | First Middle Last                            |  |
| Gabriael Moniz  |  |  |  |   |  |   |  | Angelina Pachio          |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown)  |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | Address                  |  |  |  |
|   |  |  |  | 052 12 0393   |  | Hospital records  |  | Cheverly, Md.            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Cardiac Tamponade</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Heart Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>4201</u>   |  |  |  |   |  |   |  |                          |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |                          |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |                          |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |                          |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>Oct. 10, 1968</u> , to <u>Oct. 16, 1968</u> , that (we) last saw the deceased alive on <u>Oct. 16, 1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |                          |  |  |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS  |  |                          |  |  |  |
| <u>Moniz</u>  |  | <u>10/16/68</u>  |  | <u>T. J. HERRANDEZ MD</u>   |  | <u>PRINCE GEO. GEN. HOSP. MD</u>  |  |                          |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)                                     |  |                          |  |  |  |
| Burial  |  | Oct 19, 1968   |  | Pine Lawn Cemetery  |  | Long Island Queens N Y  |  |                          |  |  |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                          |  |  |  |
| F. Gasch's Sons   |  | Hyattsville, Md.   |  | DATE OCT 21 1968  |  | <u>Charles Judge</u>  |  |                          |  |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |   |                                 |  |
|---|--|--|---|---------------------------------|--|
| 14914<br>Item 23 Film G405 10/21/68 kk  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |   | 14924                           |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First   | Middle                          | Last   |
| Josephine   |  |  | Moore   |                                 |  |
| 2. DATE OF DEATH  |  |  | Month   | Day                             | Year   |
| Oct.  |  |  | 10  | 10                              | 1968   |
| 2b. HOUR  |  |  | 10:30 <sup>A</sup>  |                                 |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   |   | 6. AGE (In years lost birthday) | 7. IF UNDER 1 YEAR MONTHS                    |
| Female  | Negro  | Dec 9, 1912  |   | 55 YRS.                         | IF UNDER 24 HRS. HOURS MIN.                  |
| 7a. BIRTHPLACE (State or foreign country)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH  |                                 |  |
| Va  | U S A  | Prince George's Md.  |   |                                 |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  | 12b. KIND OF BUSINESS OR INDUSTRY   |                                 |  |
| Cheverly  | Prince Geo. Gen'l Hospital   | Domestic   | Housework   |                                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER          |  |
| Maryland  | Prince George's  | Deanwood Pk  |   | 5010 Nash St., NE.              |  |
| 14. FATHER'S NAME   | First  | Middle   | Last  | 15. MOTHER'S MAIDEN NAME        | First Middle Last                            |
| Robert Banks  |  |  |   | Mariett Jones                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO   | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service)               | 17. INFORMANT Address  |   |                                 |  |
|   | 230 38 5401  | Hospital records Cheverly, Md.   |   |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4319 IMMEDIATE CAUSE (a) Cerebral Hemorrhage<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>331X  |  |  |   |                                 |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |                                 |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No.   | City or Town  | County                          | State  |
| 22a. I certify that (1) (this hospital) attended the deceased from Sept. 23, 1968, to Oct. 9, 1968, that (1) (we) lost the deceased alive on Oct. 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.                                       |  |  |   |                                 |  |
| 22b. SIGNATURE  | DEGREE   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          | 22c. DATE SIGNED  |                                 |  |
| 22d. PHYSICIAN'S NAME (Type)  | 22e. ADDRESS   |  | Oct. 9, 1968  |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION (City or Town)    | (County) Maryland                            |
| Burial  |  | 10/12/68   | Oakwood   | Chesville Pa                    |  |
| 24. FUNERAL DIRECTOR  | ADDRESS  |  | 25a. REC'D BY REGISTRAR   | 25b. REGISTRAR'S SIGNATURE      |  |
| F. Gasch's Sons   | Hyattsville, Maryland  |  | DATE OCT 14 1968  | Charles Judge                   |  |

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DEPARTMENT OF STATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 7-68

14915

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14925

|  |  |   |  |   |  |   |   |   |   |   |  |
|--|--|---|--|---|--|---|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Maude C. Moore</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>October</b> Day <b>13</b> Year <b>1968</b>   |   |  | 2b. HOUR<br><b>8:25</b> A. M.   |   |   |   |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>                       |  | 5. DATE OF BIRTH<br><b>June 28, 1891</b>  |  | 6. AGE (In years last birthday)<br><b>77</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   | IF UNDER 24 HRS.<br>HOURS MIN.                          |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Prince Georges</b> Md.   |   |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Glenn Dale</b>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Glenn Dale Hospital</b>                             |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Unknown - Retired</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b> |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br><b>D.C.</b>   |  |   |  | 13b. COUNTY<br><b>Washington</b>  |  | 13c. CITY OR TOWN<br><b>Washington</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>2905 Nelson Place S.E.</b> |  |
| 14. FATHER'S NAME<br>First <b>William</b> Middle <b>Couch</b> Last <b>Couch</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Elizabeth</b> Middle <b>Bruffy</b> Last <b>Bruffy</b>   |   |  |   |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)  |  |   | 16b. SOCIAL SECURITY NO.<br><b>577-10-5449</b>   |   |  | 17. INFORMANT<br><b>Decedent</b> Address  |   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b><br><b>4369</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>hemiparesis &amp; speech abnormality</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>337X</b><br>(b) <b>left cerebrovascular accident with rt.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>generalized arteriosclerosis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>3 yrs.</b><br><b>years</b> |  |   |  |   |  |   |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Mechanical intestinal obstruction, improved; fracture of right femur, 2/68, treated by traction, healed.</b>   |  |   |  |   |  |   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                     |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>8/3/</b> , 19 <b>66</b> , to <b>10/13/</b> , 19 <b>68</b> , that (X) (we) lost saw the deceased alive on <b>10/13/</b> , 19 <b>68</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) <b>not</b> view the body after death.   |  |   |  |   |  |   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Moe Weiss</b>   |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>10/13/1968</b>   |   |   |   |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>  |  |   | 22e. ADDRESS<br><b>Glenn Dale Hospital<br/>Glenn Dale, Maryland</b>  |   |  |   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>Oct. 16, 1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cemetery</b> |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Colmar Manor P.D. Md.</b> |   |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>Jerome Fred House</b>   |  |   | ADDRESS<br><b>1400 14th St. N.W.</b>   |   |  | CITY<br><b>Washington, D.C.</b>   |   | 25. RECD BY REGISTRAR<br><b>Charles Judge</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>      |  |
| DATE<br><b>OCT 15 1968</b>   |  |   |  |   |  |   |   |   |   |   |  |

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UNITED STATES OF AMERICA

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Generalized arterial sclerosis  
Late cerebrovascular accident with  
hemiparesis & sensory abnormality  
of the right side  
Generalized arterial sclerosis  
Late cerebrovascular accident with  
hemiparesis & sensory abnormality  
of the right side

Generalized arterial sclerosis  
Late cerebrovascular accident with  
hemiparesis & sensory abnormality  
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of the right side  
Generalized arterial sclerosis  
Late cerebrovascular accident with  
hemiparesis & sensory abnormality  
of the right side



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

| <div style="display: flex; justify-content: space-between;"> <span>14910</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>14926</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b><br/> <small>Item 5 Film 405 10/15/68</small> </div>  |  |  |  |  |  |   |   |  |                          |                                   |          |  |  |
|---|--|--|--|--|--|---|---|--|--------------------------|-----------------------------------|----------|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  |  | Middle   |   | Last  |  | 2a. DATE OF DEATH        |                                   | 2b. HOUR |  |  |
| Dela  |  |  |  |  | Moreland   |   |   |  | Oct Month 5 Day Year 68  |                                   | 7:40PM   |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |   |   | 6. AGE (In years last birthday)                                      |                          | IF UNDER 1 YEAR MONTHS DAYS       |          | IF UNDER 24 HRS. HOURS MIN.                  |  |
| Female  |  | Cauc.  |  | 12-19-1892   |  |   |   | 76 YRS.  |                          |                                   |          |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |   |  |                          |                                   |          |  |  |
| Maryland  |  | U S A  |  |  |  | Prince Georges Md.  |   |  |                          |                                   |          |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                          | 12b. KIND OF BUSINESS OR INDUSTRY |          |  |  |
| Cheverly  |  |  | Prince Georges Gen. Hosp.  |  |  |   | Housewife   |  |                          |                                   |          |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN                                |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 13e. STREET AND NUMBER   |                                   |          |  |  |
| Md.   |  |  | Prince Georges   |  | Capitol Hgts                                     |   |   |  | 513 61st Avenue          |                                   |          |  |  |
| 14. FATHER'S NAME   |  |  | First  |  | Middle   |   | Last  |  | 15. MOTHER'S MAIDEN NAME |                                   |          | First Middle Last                            |  |
| Elsroed   |  |  | ?  |  | Elsroed  |   |   |  | Unknown                  |                                   |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address                            |   |   |  |                          |                                   |          |  |  |
| No.   |  |  |  |  | Ernest E. Moreland 513-61st Ave. Capt. Hgts. Md. |   |   |  |                          |                                   |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |   |  |                          |                                   |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |   |  |                          |                                   |          |  |  |
| IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>   |  |  |  |  |  |   |   |  |                          |                                   |          |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |   |  |                          |                                   |          |  |  |
| (b) <u>Pulmonary Edema</u>  |  |  |  |  |  |   |   |  |                          |                                   |          |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |   |  |                          |                                   |          |  |  |
| (c) <u>Massive Pneumonia Right Lung</u>   |  |  |  |  |  |   |   |  |                          |                                   |          |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |   |   |  |                          |                                   |          |  |  |
| 493X  |  |  |  |  |  |   |   |  |                          |                                   |          |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                          |                                   |          |  |  |
|   |  |  |  |  |  |   |   |  |                          |                                   |          |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |   |  |                          |                                   |          |  |  |
|   |  | HOUR A.M. Month Day Year P.M. 19   |  |  |  |   |   |  |                          |                                   |          |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |  |   |   |  |                          |                                   |          |  |  |
|   |  |  |  | Street or R.F.D. No. City or Town County State   |  |   |   |  |                          |                                   |          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 7</u> , 19 <u>68</u> , to <u>Oct. 5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct. 5</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |   |  |                          |                                   |          |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |   |   |  |                          |                                   |          | 22c. DATE SIGNED                             |  |
| <u>William Brainin</u>  |  |  |  |  |  |   |   |  |                          |                                   |          | <u>10/11/68</u>                              |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |  |  |   |   |  |                          |                                   |          |  |  |
| WM BRAININ  |  | 6056 Central Ave, Capitol Hgts Md  |  |  |  |   |   |  |                          |                                   |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |   |   | 23d. LOCATION (City or Town) (County) (State)                        |                          |                                   |          |  |  |
| Burial  |  | 10-9-68  |  | Cedar Hill Cemetery  |  |   |   | Suitland Pr. Geo. Md.  |                          |                                   |          |  |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |  |  |  | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |                          |                                   |          |  |  |
| Wilhelm Funeral Home  |  | 4308 Suitland Rd.  |  |  |  | DATE OCT 11 1968  |   | <u>Charles Judge</u>   |                          |                                   |          |  |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |         |  |  |   |  |   |   |                          |  |
|---|---------|--|--|---|--|---|---|--------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |  |  |   |  |   |   |                          |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |  |  |   |  |   |   |                          |  |
| 1. DECEASED-NAME<br>(Type or Print)   |         |  | First Middle Last  |   |  | 2a. DATE KNOWN OF DEATH   |   |                          | 2b. HOUR   |
| Suzanne Lea Morris  |         |  |  |   |  | Month Day Year  |   |                          | 10:00am  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (in years last birthday)  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.  |   | 2c. DATE PRONOUNCED DEAD |  |
| Female  | White   | 10-22-1939   | 28 YRS.  | MONTHS  | DAYS   | HOURS   | MIN.  | Month Day Year           | 10 3 68 12:45pm  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |   |                          |  |
| Vermont   |         | U S A  |  |   |  | Prince George's Md.   |   |                          |  |
| 10. CITY OR TOWN OF DEATH   |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |                          | 12b. KIND OF BUSINESS OR INDUSTRY  |
| Bowie   |         |  | 4014 Croydon Lane  |   |  | housewife   |   |                          | home   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission to hospital)   |         |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?  |                          | 13e. STREET AND NUMBER   |
| Maryland  |         |  | Prince George's  |   | Bowie  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 |                          | 4014 Croydon Lane  |
| 14. FATHER'S NAME   |         |  | 15. MOTHER'S MAIDEN NAME   |   |  |   |   |                          |  |
| Charles Coleman   |         |  | Grace Dersoa   |   |  |   |   |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |   |   |                          |  |
| no  |         |  |  |   | Lawrence W Morris Bowie, Md.   |   |   |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple stab wounds of chest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>And multiple lacerations of neck</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |         |  |  |   |  |   |   |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Minutes</u><br><u>Minutes</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |  |  |   |  |   |   |                          |  |
| 19a. DATE OF OPERATION  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |   |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                          |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  | 21b. TIME OF INJURY Month, Day, Year<br>10:00am 10-3-19 68                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Attacked by assailant |   |   |                          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK   |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>home |  | 21f. LOCATION Street or R.F.D. No.<br>Same as #13   |  | City or Town  |   | County                   | State  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |  |  |   |  |   |   |                          |  |
| ACTUAL SIGNATURE<br><u>John Kehoe</u> MD  |         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                              |   |  | 22b. DATE SIGNED<br>10-4-68   |   |                          |  |
| EXAMINER'S NAME (Type)<br>John Kehoe MD   |         |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                  |   |  | ADDRESS (Street, city, town, or county)<br>Riverdale, Md.                               |   |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town)  |   | (County)                 | (State)  |
| Burial  |         | Oct 6, 1968  |  | Scottsville Cemetery  |  | Danby   |   |                          | Vermont  |
| 24. FUNERAL DIRECTOR  |         |  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |   |                          |  |
| F. Gasch's Sons Hyattsville, Md.  |         |  |  | OCT 8 1968  |  | Charles Judge   |   |                          |  |

1941

1941

INTERNAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

|   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |     |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|

|                     |  |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |
|---------------------|--|--|--|--|--|--|--|--|--|--------|--|--|--|--|--|--|--|--|--|--------|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|--------------------|--|--|--|--|--|--|--|--|--|---------------------------|--|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|--|--------------------------|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|--------------------------|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|
| 1. Name of deceased |  |  |  |  |  |  |  |  |  | 2. Sex |  |  |  |  |  |  |  |  |  | 3. Age |  |  |  |  |  |  |  |  |  | 4. Date of death |  |  |  |  |  |  |  |  |  | 5. Place of death |  |  |  |  |  |  |  |  |  | 6. Cause of death |  |  |  |  |  |  |  |  |  | 7. Manner of death |  |  |  |  |  |  |  |  |  | 8. Signature of physician |  |  |  |  |  |  |  |  |  | 9. Signature of medical examiner |  |  |  |  |  |  |  |  |  | 10. Signature of coroner |  |  |  |  |  |  |  |  |  | 11. Signature of registrar |  |  |  |  |  |  |  |  |  | 12. Signature of clerk |  |  |  |  |  |  |  |  |  | 13. Signature of nurse |  |  |  |  |  |  |  |  |  | 14. Signature of janitor |  |  |  |  |  |  |  |  |  | 15. Signature of other |  |  |  |  |  |  |  |  |  |
|---------------------|--|--|--|--|--|--|--|--|--|--------|--|--|--|--|--|--|--|--|--|--------|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|--------------------|--|--|--|--|--|--|--|--|--|---------------------------|--|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|--|--------------------------|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|--------------------------|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|

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| 16. Name of hospital |  |  |  |  |  |  |  |  |  | 17. Name of doctor |  |  |  |  |  |  |  |  |  | 18. Name of nurse |  |  |  |  |  |  |  |  |  | 19. Name of janitor |  |  |  |  |  |  |  |  |  | 20. Name of other |  |  |  |  |  |  |  |  |  | 21. Name of registrar |  |  |  |  |  |  |  |  |  | 22. Name of clerk |  |  |  |  |  |  |  |  |  | 23. Name of physician |  |  |  |  |  |  |  |  |  | 24. Name of medical examiner |  |  |  |  |  |  |  |  |  | 25. Name of coroner |  |  |  |  |  |  |  |  |  | 26. Name of other |  |  |  |  |  |  |  |  |  | 27. Name of other |  |  |  |  |  |  |  |  |  | 28. Name of other |  |  |  |  |  |  |  |  |  | 29. Name of other |  |  |  |  |  |  |  |  |  | 30. Name of other |  |  |  |  |  |  |  |  |  | 31. Name of other |  |  |  |  |  |  |  |  |  | 32. Name of other |  |  |  |  |  |  |  |  |  | 33. Name of other |  |  |  |  |  |  |  |  |  | 34. Name of other |  |  |  |  |  |  |  |  |  | 35. Name of other |  |  |  |  |  |  |  |  |  | 36. Name of other |  |  |  |  |  |  |  |  |  | 37. Name of other |  |  |  |  |  |  |  |  |  | 38. Name of other |  |  |  |  |  |  |  |  |  | 39. Name of other |  |  |  |  |  |  |  |  |  | 40. Name of other |  |  |  |  |  |  |  |  |  | 41. Name of other |  |  |  |  |  |  |  |  |  | 42. Name of other |  |  |  |  |  |  |  |  |  | 43. Name of other |  |  |  |  |  |  |  |  |  | 44. Name of other |  |  |  |  |  |  |  |  |  | 45. Name of other |  |  |  |  |  |  |  |  |  | 46. Name of other |  |  |  |  |  |  |  |  |  | 47. Name of other |  |  |  |  |  |  |  |  |  | 48. Name of other |  |  |  |  |  |  |  |  |  | 49. Name of other |  |  |  |  |  |  |  |  |  | 50. Name of other |  |  |  |  |  |  |  |  |  | 51. Name of other |  |  |  |  |  |  |  |  |  | 52. Name of other |  |  |  |  |  |  |  |  |  | 53. Name of other |  |  |  |  |  |  |  |  |  | 54. Name of other |  |  |  |  |  |  |  |  |  | 55. Name of other |  |  |  |  |  |  |  |  |  | 56. Name of other |  |  |  |  |  |  |  |  |  | 57. Name of other |  |  |  |  |  |  |  |  |  | 58. Name of other |  |  |  |  |  |  |  |  |  | 59. Name of other |  |  |  |  |  |  |  |  |  | 60. Name of other |  |  |  |  |  |  |  |  |  | 61. Name of other |  |  |  |  |  |  |  |  |  | 62. Name of other |  |  |  |  |  |  |  |  |  | 63. Name of other |  |  |  |  |  |  |  |  |  | 64. Name of other |  |  |  |  |  |  |  |  |  | 65. Name of other |  |  |  |  |  |  |  |  |  | 66. Name of other |  |  |  |  |  |  |  |  |  | 67. Name of other |  |  |  |  |  |  |  |  |  | 68. Name of other |  |  |  |  |  |  |  |  |  | 69. Name of other |  |  |  |  |  |  |  |  |  | 70. Name of other |  |  |  |  |  |  |  |  |  | 71. Name of other |  |  |  |  |  |  |  |  |  | 72. Name of other |  |  |  |  |  |  |  |  |  | 73. Name of other |  |  |  |  |  |  |  |  |  | 74. Name of other |  |  |  |  |  |  |  |  |  | 75. Name of other |  |  |  |  |  |  |  |  |  | 76. Name of other |  |  |  |  |  |  |  |  |  | 77. Name of other |  |  |  |  |  |  |  |  |  | 78. Name of other |  |  |  |  |  |  |  |  |  | 79. Name of other |  |  |  |  |  |  |  |  |  | 80. Name of other |  |  |  |  |  |  |  |  |  | 81. Name of other |  |  |  |  |  |  |  |  |  | 82. Name of other |  |  |  |  |  |  |  |  |  | 83. Name of other |  |  |  |  |  |  |  |  |  | 84. Name of other |  |  |  |  |  |  |  |  |  | 85. Name of other |  |  |  |  |  |  |  |  |  | 86. Name of other |  |  |  |  |  |  |  |  |  | 87. Name of other |  |  |  |  |  |  |  |  |  | 88. Name of other |  |  |  |  |  |  |  |  |  | 89. Name of other |  |  |  |  |  |  |  |  |  | 90. Name of other |  |  |  |  |  |  |  |  |  | 91. Name of other |  |  |  |  |  |  |  |  |  | 92. Name of other |  |  |  |  |  |  |  |  |  | 93. Name of other |  |  |  |  |  |  |  |  |  | 94. Name of other |  |  |  |  |  |  |  |  |  | 95. Name of other |  |  |  |  |  |  |  |  |  | 96. Name of other |  |  |  |  |  |  |  |  |  | 97. Name of other |  |  |  |  |  |  |  |  |  | 98. Name of other |  |  |  |  |  |  |  |  |  | 99. Name of other |  |  |  |  |  |  |  |  |  | 100. Name of other |  |  |  |  |  |  |  |  |  |
|----------------------|--|--|--|--|--|--|--|--|--|--------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-----------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-----------------------|--|--|--|--|--|--|--|--|--|------------------------------|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|--------------------|--|--|--|--|--|--|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1-68)  
30M REV. 1-68

14919

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14928

|   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Mary M. Murphy</b>  |  |   | 2a. DATE OF DEATH<br>10 Month 6 Day 68 Year                            |   |  | 2b. HOUR<br>6:15 P   |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br><b>3/18/94</b>  |  | 6. AGE (In years last birthday)<br><b>74</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Prince Georges</b> Md.                                      |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Clinton</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Clinton Community Hosp., Corp.</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Base and Home</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Charles</b>   |  | 13c. CITY OR TOWN<br><b>Waldorf</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>Rt. 3 Box 438</b>                  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Daniel Bridgett</b>   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary Julia Murphy</b> |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-42-4554</b>  |  | 17. INFORMANT Address<br><b>Mary Lillian Buckler/Rd. Oxon Hill, Md.</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>GENERAL VISCERAL FAILURE</b><br><b>2509</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>GEN. ARTERIO-SCLEROSIS</b><br>(b) <b>DIMINISHED MYELIN</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>last. <b>250X</b> (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 WEEKS</b> |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>K-S-W with DICEMIA.</b>   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/5</b> , 19 <b>68</b> , to <b>10/6</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/6/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Robert W. Merkle</b><br>DEGREE   |  |   |  | 22c. DATE SIGNED<br><b>10-6-68</b>  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>Robert W. Merkle, M.D.</b>                        |  |   |  |
| 22e. ADDRESS<br><b>Clinton Community Hospital Corp.</b><br><b>7945 Woodyard Rd., Clinton, Maryland</b>  |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>10-9-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST PETERS CEM.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>WALDORF CHARLES, MD.</b>         |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Funeral Home, Waldorf, Md.</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>DATE OCT 14 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Jones</b>                                  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| 14919   |  |  |  |  |   |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |  |  |  |  | 14929                                   |  |  |  |  |                             |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|-----------------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print) MARVIN THOMAS NEAL, SR.  |  |  |  |  |   |  |  |  |  | 2a. DATE OF DEATH October 18 Day 1968 Year   |  |  |  |  |   |  |  |  |  | 2b. HOUR PM 8:25M                       |  |  |  |  |                             |  |  |  |  |
| 3. SEX MALE   |  |  |  |  | 4. RACE CAU   |  |  |  |  | 5. DATE OF BIRTH Jan 7, 1912   |  |  |  |  | 6. AGE (In years last birthday) 56 YRS.   |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS             |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) KENTUCKY  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? United States  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH PRINCE GEORGE'S Md.  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |
| 10. CITY OR TOWN OF DEATH ALEX  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcom Grow USAF HOSP. |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) USAF-ADMINISTRATION  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY MILITARY  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND  |  |  |  |  | 13b. CITY OR TOWN PRINCE GEORGES  |  |  |  |  | 13c. CITY OR TOWN FORESTVILLE  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  |  |  |  | 13e. STREET AND NUMBER 8205 BELTZ DRIVE |  |  |  |  |                             |  |  |  |  |
| 14. FATHER'S NAME First Middle Last THOMAS - NEAL   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last PUGH   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) YES 1938-1961  |  |  |  |  | 16b. SOCIAL SECURITY NO. 291-03-6606  |  |  |  |  | 17. INFORMANT Address POPPY P. NEAL 8205 BELTZ DR. FORRESTVILLE, MD.   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS<br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) SEVERE CORONARY ARTERIOSCLEROSIS<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |  |   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>REMOTE MYOCARDIAL INFARCTION  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 18 Oct, 1968, to 18 Oct, 1968, that (I) (we) last saw the deceased alive on 18 Oct 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |
| 22b. SIGNATURE John Goldman, M.D. DEGREE  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED 19 Oct 68              |  |  |  |  |                             |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) JOHN GOLDMAN, M.D.   |  |  |  |  |   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS USAF HOSP. ANDREWS, PRINCE GEORGES, MD.  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  |  |  |  | 23b. DATE 10-23-68  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) Arlington Virginia  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |
| 24. FUNERAL DIRECTOR W.W. Chambers  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | ADDRESS 517-1125 S.E.   |  |  |  |  | 25a. REC'D BY REGISTRAR OCT 30 1968     |  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |

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*Smith*

*Smith*

10-2-28

*Washington, D.C.*  
*2111 1/2 St.*  
*N.E.*

*Washington, Virginia*

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 13. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14920

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14930

|  |  |                         |   |                                       |  |   |  |                                |   |  |  |
|--|--|-------------------------|---|---------------------------------------|--|---|--|--------------------------------|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print)<br><b>Minnie</b>   |  |                         | First Middle Last   |                                       |  | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> Month Day Year<br><b>10-16-68</b>  |  |                                | 2b. HOUR<br><b>15pm</b>   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b> |   | 5. DATE OF BIRTH<br><b>10-25-1878</b> |  | 6. AGE (In years lost birthday)<br><b>89</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>   |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                       |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>           |  |                                | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.                                    |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hyattsville</b>  |  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Hyattsville Nursing home</b> |                                       |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Homemaker</b>   |  |                                | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br><b>District of Columbia</b>   |  |                         | 13b. CITY OR TOWN<br><b>Washington</b>  |                                       |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                                | 13e. STREET AND NUMBER<br><b>5521 Colorado Ave. N.W.</b>                            |  |  |
| 14. FATHER'S NAME<br><b>W. C. Gardner</b>  |  |                         | First Middle Last   |                                       |  | 15. MOTHER'S MAIDEN NAME<br><b>Unobtainable</b>   |  |                                | First Middle Last   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>no</b>   |  |                         | 16b. SOCIAL SECURITY NO.<br><b>578-60-9266</b>  |                                       |  | 17. INFORMANT<br><b>Marion L. Boat-7520 17th St. N.W. Washington, DC</b>  |  |                                |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Malnutrition</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Anorexia</b><br>(b) <b>From Generalized arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |                         |   |                                       |  |   |  |                                |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>over 1 mo.</b><br><b>over 1 mo.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4500 Fracture of right hip - 8-26-68</b>   |  |                         |   |                                       |  |   |  |                                |   |  |  |
| 19a. DATE OF OPERATION   |  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                                       |  |   |  |                                | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/><br>CAUSE OF DEATH   |  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. PM P.M. <b>8-26-1968</b>                                      |                                       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Fell at Hyattsville Nursing Home</b>  |  |                                |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Hyattsville Nursing Home</b> |                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>6500 Riggs Rd., Hyattsville, P.G. Co., Md.</b>   |  |                                |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |                         |   |                                       |  |   |  |                                |   |  |  |
| ACTUAL SIGNATURE<br><b>John Kehoe</b>  |  |                         | EXAMINER'S NAME (Type)<br><b>John Kehoe MD Riverdale, Md.</b>   |                                       |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |                                | 22b. DATE SIGNED<br><b>10-17-68</b>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>  |  |                         | 23b. DATE<br><b>10/18/68</b>  |                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Crematory</b>  |  |                                | 23d. LOCATION (City or Town) (County) (State)<br><b>Prince Georges Co. Md.</b>      |  |  |
| 24. FUNERAL DIRECTOR<br><b>The S. H. Hines Company</b><br><b>2901 14th St. N.W. Washington, DC</b>   |  |                         |   |                                       |  | 25a. REC'D BY REGISTRAR<br><b>OCT 21 1968</b>   |  |                                | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>                                |  |  |

14330

14330

DEPARTMENT OF HEALTH

|                |  |                   |  |                    |  |                    |  |                      |  |
|----------------|--|-------------------|--|--------------------|--|--------------------|--|----------------------|--|
| Name           |  | Address           |  | City               |  | State              |  | Zip                  |  |
| John Doe       |  | 123 Main St       |  | New York           |  | NY                 |  | 10001                |  |
| Age            |  | Sex               |  | Race               |  | Religion           |  | Occupation           |  |
| 35             |  | Male              |  | White              |  | Catholic           |  | Engineer             |  |
| Date of Birth  |  | Date of Admission |  | Date of Discharge  |  | Date of Death      |  | Cause of Death       |  |
| 01-15-1945     |  | 03-10-1946        |  | 05-20-1946         |  | 06-15-1946         |  | Heart Disease        |  |
| Place of Birth |  | Place of Death    |  | Place of Burial    |  | Place of Interment |  | Place of Cremation   |  |
| New York       |  | New York          |  | New York           |  | New York           |  | New York             |  |
| Date of Death  |  | Date of Burial    |  | Date of Interment  |  | Date of Cremation  |  | Date of Reinterment  |  |
| 06-15-1946     |  | 06-20-1946        |  | 06-25-1946         |  | 07-01-1946         |  | 07-05-1946           |  |
| Place of Death |  | Place of Burial   |  | Place of Interment |  | Place of Cremation |  | Place of Reinterment |  |
| New York       |  | New York          |  | New York           |  | New York           |  | New York             |  |
| Date of Death  |  | Date of Burial    |  | Date of Interment  |  | Date of Cremation  |  | Date of Reinterment  |  |
| 06-15-1946     |  | 06-20-1946        |  | 06-25-1946         |  | 07-01-1946         |  | 07-05-1946           |  |
| Place of Death |  | Place of Burial   |  | Place of Interment |  | Place of Cremation |  | Place of Reinterment |  |
| New York       |  | New York          |  | New York           |  | New York           |  | New York             |  |

Order of 10/15/88 St. Lincoln Cemetery, 17400 Georges Co. Rd.  
The S. H. Hines Company  
2901 14th St. N.W. Washington, DC 20001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14921

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14931

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>ERMA SIZER NOTTINGHAM</b>   |  |   | 2a. DATE OF DEATH<br>10 Month 16 Day 68 YRS |   |  | 2b. HOUR<br>3:38 PM   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br><b>5-23-1907</b>  |  | 6. AGE (In years last birthday)<br><b>61</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><del>CLINTON</del> <b>Prince Georges</b> Md.                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>CLINTON, Md.</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>PINE VIEW GARDEN</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>House wife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Charles</b>   |   | 13c. CITY OR TOWN<br><b>La Plata</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER   |  | 14. FATHER'S NAME<br>First Middle Last<br><b>Edward Sizer</b>   |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Mattie Jackson</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>578-12-7060</b>  |   | INFORMANT<br><b>Mr. Benjamin J. Nottingham-Son Spring</b>   |  | 9600 Avenue Rd. Silver  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Circulatory Collapse</b><br><b>4369</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Pneumonia, bronchial</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>C.V.A. &amp; Pulmonary Emboli</b> |  |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>331X</b>  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9</b> - <b>10/16/68</b> , to <b>10/16/68</b> , that (I) (we) last saw the deceased alive on <b>10/16/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Alfred R Lapin</b>  |  | DEGREE<br><b>ALFRED R LAPIN</b>   |   | ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22c. DATE SIGNED<br><b>10/16/1968</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>ALFRED R LAPIN</b>  |  | 22e. ADDRESS<br><b>Clinton, Maryland</b>  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, or other disposition<br><b>Burial</b>  |  | 23b. DATE<br><b>10/19/1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Bladensburg, Maryland</b>                   |  |
| 24. FUNERAL DIRECTOR<br><b>Richard Funeral Home, Inc. Md.</b>  |  | ADDRESS   |   | RESPECT BY REGISTRAR<br><b>10/23/68</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

MEDICAL CERTIFICATION

14931

14931

Female White  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 11-67

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |   |                                   |  |
|---|--|--|--|--|--|---|---|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |   |                                   |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |   |                                   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH   |   |                                   | 2b. HOUR                                     |
| John E. Owens   |  |  |  |  |  | Oct. 2, 1968  |   |                                   | 3 P. M.                                      |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |   | 6. AGE (In years last birthday)   |                                   | IF UNDER 1 YEAR MONTHS DAYS                  |
| Male  |  | Caucasian  |  | March 29, 1886   |  |   | 82 YRS.   |                                   | IF UNDER 24 HRS. HOURS MIN.                  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |   |                                   |  |
| Maryland  |  | U. S. A.   |  |  |  | Prince George's Md.   |   |                                   |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Cheverly  |  |  | Prince Geo. Gen'l Hospital   |  |  | Gardener  |   | Florist                           |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |
| Maryland  |  |  | Prince George's  |  | Oxon Hill  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |                                   | 5600 Livingston Rd.                          |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |   |   |                                   |  |
| John D. Owens   |  |  | Elizabeth McQuade  |  |  |   |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |   |   |                                   |  |
| No  |  |  | 577-26-6591  |  | Charles A. Owens, North Beach Md.  |   |   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |   |                                   |  |
| IMMEDIATE CAUSE (a) 4109 CARDIAC AND RESPIRATORY ARREST   |  |  |  |  |  |   |   |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |   |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201   |  |  |  |  |  |   |   |                                   |  |
| (b) Acute myocardial infarction   |  |  |  |  |  |   |   |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |   |                                   |  |
| (c) Arteriosclerotic cardiovascular disease   |  |  |  |  |  |   |   |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |   |   |                                   |  |
| Malnutrition - Severe dehydration.  |  |  |  |  |  |   |   |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |                                   |  |
|   |  |  |  |  |  |   |   |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |   |                                   |  |
|   |  |  |  |  |  |   |   |                                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town  |   | County State                      |  |
|   |  |  |  |  |  |   |   |                                   |  |
| 22a. I certify that (this hospital) attended the deceased from Sept. 30, 1968, to Oct. 2, 1968, that (we) lost saw the deceased alive on Oct. 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |   |                                   |  |
| 22b. SIGNATURE Luis F. Bentolila  |  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED 10-3-68  |                                   |  |
| 22d. PHYSICIAN'S NAME (Type) Luis F. Bentolila, M. D.   |  |  |  |  | 22e. ADDRESS Prince Geo. Gen'l Hospital, Cheverly, Md.   |   |   |                                   |  |
| 23a. BURIAL-CREMATATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |   |                                   |  |
| Burial  |  | 10-5-68  |  | Washington National  |  | Suitland P. Geo. Md.  |   |                                   |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |  | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |                                   |  |
| W. W. Chambers Co. 517-11 S. E.   |  |  |  |  | DATE OCT 9 1968  |   | Charles Jones   |                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14922

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14933

|   |  |  |   |   |   |   |   |  |  |                                |  |
|---|--|--|---|---|---|---|---|--|--|--------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)<br>Salvadora Salvator M. Petrone  |  |  | First Middle Last   |   |   | 2a. DATE OF DEATH<br>Month Day Year<br>Oct. 4, 1968   |   |  | 2b. HOUR<br>1:30A M  |                                |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian                   |   | 5. DATE OF BIRTH<br>4/29/02   |   | 6. AGE (In years last birthday)<br>66 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                 |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Wash., D.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Prince George's Md.   |   |  |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Cheverly   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Prince Geo.Gen'l Hospital |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br>Ret. U.S. Post Office |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-                               |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  |  | 13b. COUNTY<br>Prince George's  |   | 13c. CITY OR TOWN<br>Riverdale                                  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>60700 3rd St.                              |                                |  |
| 14. FATHER'S NAME<br>Claude Petrone   |  |  | First Middle Last   |   |   | 15. MOTHER'S MAIDEN NAME<br>Ella Storty   |   |  | First Middle Last  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service)<br>1-27-59   |  |  | 16b. SOCIAL SECURITY NO.<br>577-58-7333   |   | 17. INFORMANT<br>Mrs. Lucy F. Petrone (above address) (wife)    |   |   |  |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS<br>1991 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) CARCINOMA OF RT CHOANAL<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 MONTHS<br>1 YEAR. |  |  |   |   |   |   |   |  |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>1992  |  |  |   |   |   |   |   |  |  |                                |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                 |   |  |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |                                |  |
| 22a. I certify that (I) (the hospital) attended the deceased from SEP 1, 1967, to Oct. 4, 1968, that (I) last saw the deceased alive on Oct. 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.   |  |  |   |   |   |   |   |  |  |                                |  |
| 22b. SIGNATURE<br>Samuel J. N. Sugar MD<br>DEGREE   |  |  |   |   |   | 22c. DATE SIGNED<br>Oct. 4, 1968  |   |  | 22d. PHYSICIAN'S NAME (Type)<br>Samuel J. N. Sugar, M. D.            |                                |  |
| 22e. ADDRESS<br>4637 Eastern Ave., Washington, D.C. 20018   |  |  |   |   |   |   |   |  |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  | 23b. DATE<br>10/7/68  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Stonewall Mem. Gard. Cen. |   |   | 23d. LOCATION (City or Town) (County) (State)<br>Manassas, Va. |  |                                |  |
| 24. FUNERAL DIRECTOR<br>Valley's Funeral Home Inc.  |  |  | ADDRESS<br>St. Rainier, Maryland  |   |   | 25a. REC'D BY REGISTRAR<br>DATE OCT 11 1968   |   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                          |                                |  |

14003

14003

1. Name of the person or organization to whom the letter is addressed  
2. Address of the person or organization to whom the letter is addressed  
3. City, State, and Zip Code of the person or organization to whom the letter is addressed  
4. Date of the letter  
5. Subject of the letter  
6. Salutation  
7. Body of the letter  
8. Closing  
9. Signature  
10. Enclosures

1. Name of the person or organization to whom the letter is addressed  
2. Address of the person or organization to whom the letter is addressed  
3. City, State, and Zip Code of the person or organization to whom the letter is addressed  
4. Date of the letter  
5. Subject of the letter  
6. Salutation  
7. Body of the letter  
8. Closing  
9. Signature  
10. Enclosures

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 1 Film 406 11/8/68 kk  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14924

CERTIFICATE OF DEATH

14934

|  |  |  |   |   |  |  |   |  |  |   |      |
|--|--|--|---|---|--|--|---|--|--|---|------|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Ethel</b>  |  |  | First   | Middle<br><b>M. Harper</b>  | Last<br><b>Pettit</b>                    | 2a. DATE OF DEATH<br><b>Oct.</b> Month <b>28</b> , Day <b>1968</b> Year  |   |  | 2b. HOUR<br><b>5:50A</b> M   |   |      |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>                  |   | 5. DATE OF BIRTH<br><b>9/3/79</b>   |  | 6. AGE (In years<br>last birthday)<br><b>89</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                   |      |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Md</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b> |   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.   |   |  |  |   |      |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Prince Geo.Gen'l Hospital</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Housewife</b> |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>home</b>                    |   |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Prince George's</b>   |   | 13c. CITY OR TOWN<br><b>Hyattsville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>6500 Riggs Road</b>                       |   |      |
| 14. FATHER'S NAME<br><b>John Collinson Harper</b>  |  |  | First   | Middle  | Last                                     | 15. MOTHER'S MAIDEN NAME<br><b>Rowena Hambleton Auld</b>   |   |  | First  | Middle  | Last |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>no</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>220 44 8346</b>  |   | 17. INFORMANT<br><b>Nicholas Orem Jr</b> |  |   | Address<br><b>Hyattsville, Md.</b>   |  |   |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the colon with metastasis.</b><br><b>153.8</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                   |  |  |   |   |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>153.8</b>  |  |  |   |   |  |  |   |  |  |   |      |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? <b>Yes</b> |  |   |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                |   |  |  |   |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                     |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |   |      |
| 22a. I certify that (I) <del>(the doctor)</del> attended the deceased from <b>June</b> , 19 <b>56</b> , to <b>10/28</b> , 19 <b>68</b> , that (I) <del>(we)</del> last<br>saw the deceased alive on <b>10/28</b> , 19 <b>68</b> and that in (my) <del>(we)</del> opinion death occurred on the date and hour and from the<br>causes stated above (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death. |  |  |   |   |  |  |   |  |  |   |      |
| 22b. SIGNATURE<br><b>Norman D. Compeau MD</b>  |  |  | 22c. DATE SIGNED<br><b>10/28/68</b>   |   |  | 22d. PHYSICIAN'S<br>NAME (Type) <b>NORMAN D. COMPEAU</b>   |   |  |  |   |      |
| 22e. ADDRESS<br><b>3503 PERRY ST MT RAINIER MD</b>   |  |  |   |   |  |  |   |  |  |   |      |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Entombment</b>  |  |  | 23b. DATE<br><b>Oct 30, 1968</b>  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Cemetery</b>   |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |   |      |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b>   |  |  | ADDRESS<br><b>Hyattsville Md</b>  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 31 1968</b>   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                     |   |      |

14884

11/29/68

Res K - letter from next of kin

11/29/68 - a2

Continuation of the colon with reference.

Oct 31 1968



14925

14935

## CERTIFICATE OF DEATH

|   |  |  |  |   |   |   |  |  |  |
|---|--|--|--|---|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Kucy</i>   |  | First Middle Last  |  | 2a. DATE OF DEATH<br>Month <i>10</i> Day <i>18</i> Year <i>68</i>   |   |   | 2b. HOUR<br><i>10 A</i> M  |  |  |
| 3. SEX<br><i>FEMALE</i>   |  | 4. RACE<br><i>CAUCAS.</i>  |  | 5. DATE OF BIRTH<br><i>2-9-1882</i>   |   | 6. AGE (In years last birthday)<br><i>84</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.              |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>New Jersey</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Prince George's</i> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Forestville</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Regent Nursing Home</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>housewife</i>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md.</i>   |  | 13b. COUNTY<br><i>PG</i>   |  | 13c. CITY OR TOWN<br><i>Suitland</i>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>5219 Meadowview Drive</i> |  |
| 14. FATHER'S NAME First Middle Last<br><i>Stephen Wheeler</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>Annie Hodgson</i>  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, (unknown) (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><i>Unknown</i>   |  | 17. INFORMANT Address<br><i>C.E. Shives, Same as #13 (Daughter)</i>   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>COMA</i><br><i>150X</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>150X</i><br>(b) <i>METASTATIC CARCINOMA OF OESOPHAGUS</i><br>(c) <i>150X</i>                           |  |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>ATHEROSCLEROTIC HEART DISEASE WITH CONGESTIVE HEART FAILURE</i>   |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7-13-68</i> , 19 <i>68</i> , to <i>10-15</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10-16</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><i>Oliver B. Bond MD</i>  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |   | 22c. DATE SIGNED  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>OLIVER B. BOND</i>   |  |  |  | 22e. ADDRESS<br><i>6872 RIVERDALE ROAD<br/>DUNEDON LANHAM MD 20801</i>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMAINS (Specify)   |  | 23b. DATE<br><i>10-22-68</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Laurel Grove Cemetery</i>  |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Patterson, N.J.</i>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Wilhelm Funeral Home</i><br><i>4308 Suitland Rd. SE, Suitland, Md.</i>   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <i>OCT 23 1968</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14926

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items, #5&6, Film G405 10/18/68

CERTIFICATE OF DEATH

14936

|   |  |  |   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Florence</b>   |  |  | First <b>E.</b> Middle <b>Plater</b> Last   |  |  | 2a. DATE OF DEATH<br>Month <b>October</b> Day <b>12</b> Year <b>1968</b>  |  |  | 2b. HOUR<br><b>8:00 PM</b>   |  |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>Negro</b>   |  |  | 5. DATE OF BIRTH<br><b>5-10-1942</b>  |  |  | 6. AGE (In years lost birthday)<br><b>176</b> YRS.   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Prince Georges</b> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Riverdale</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>E. Leland Memorial</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Domestic</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Washington, D.C.</b>  |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN<br><b>Washington</b>  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  |  |
| 13e. STREET AND NUMBER<br><b>126 46th St., S.E.</b>   |  |  | 14. FATHER'S NAME<br>First <b>Wesley</b> Middle <b>Parker</b> Last  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Sara</b> Middle <b>Brown</b> Last  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>unknown</b> (If yes give war or dates of service) |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>216-16-5230</b>  |  |  | 17. INFORMANT<br><b>Roland Plater</b>   |  |  | Address<br><b>Prince Frederick-Md.</b>  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CVA</b><br><b>4369</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>331X</b><br>(b) <b>Arteriosclerosis cerebri</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Arteriosclerosis generalized</b>   |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-27</b> , 19 <b>68</b> , to <b>10-12</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-12</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>D. R. Purdie, MD</b>   |  |  | DEGREE<br><b>MD</b>   |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |  | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  | 22e. ADDRESS  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE<br><b>10-12-68</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Hope Ch. Cem</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Sunderland Cal. Md</b>   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Parkney E. Sewell</b>  |  |  | ADDRESS<br><b>Prince Med, Md.</b>   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 15 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |

14833

14833

RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.  
OFFICE OF THE SECRETARY  
ATTENTION: ASSISTANT SECRETARY  
FOR AGRICULTURAL POLICY  
MAIL ROOM  
MAIL STOP 100  
WASHINGTON, D.C. 20250

U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C. 20250  
OFFICE OF THE SECRETARY  
ATTENTION: ASSISTANT SECRETARY  
FOR AGRICULTURAL POLICY  
MAIL ROOM  
MAIL STOP 100  
WASHINGTON, D.C. 20250

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil on page 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 5, 8, 13, 16 & 17 of Maryland State Department of Health  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 1 Film 4105  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14937

|   |                         |  |   |   |   |  |   |  |
|---|-------------------------|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(Type or Print)<br><b>Stanley P. Pogorzelski</b>  |                         |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> <b>10-13-68</b> 11:00pm               |   |   | 2b. HOUR   |   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>11-18-1915</b>  | 6. AGE (in years)<br>last birthday<br><b>52</b> YRS.  | 7. AF UNDER 1 YEAR<br>MONTHS<br><b>10</b>   | 8. IF UNDER 24 HRS.<br>DAYS<br><b>14</b>  | 9. HOURS<br><b>68</b>  | 10. MIN.<br><b>12:15am</b>  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year                     |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Pa.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                              |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Suitland</b>  |                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Andrews Air Force Base Hosp.</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)<br><b>transportation</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Employee</b>           |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br><b>STATE Maryland</b>  |                         |  | 13b. COUNTY<br><b>Prince George's</b>   |   | 13c. CITY OR TOWN<br><b>Suitland</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET AND NUMBER<br><b>5419 Walls Lane</b>                                    |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Peter Pogorzelski</b>  |                         |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Pauline Kolankiewicz</b>  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>Yes</b>   |                         |  | 16b. SOCIAL SECURITY NO.<br>(If yes give year or dates of service)<br><b>1941-45</b>                                |   | 17. INFORMANT<br><b>Harriet</b> ADDRESS<br><b>Mrs. Harriett Henderson Hillcrest Md.</b> |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic heart disease</b><br>(b) <b>over 3 yrs.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                         |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>4200</b>  |                         |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. <b>19</b>          |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   | 21f. LOCATION Street or R.F.D. No.  |   | City or Town   |   | County State   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |  |   |   |   |  |   |  |
| ACTUAL SIGNATURE<br><b>John Kehoe</b>   |                         |  | M.D.<br><b>John Kehoe MD</b>  |   |   | 22b. DATE SIGNED<br><b>10-14-68</b>  |   |  |
| EXAMINER'S NAME (Type)<br><b>John Kehoe MD</b>  |                         |  | ADDRESS<br><b>Riverdale, Md.</b>  |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town, or county) |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                         | 23b. DATE<br><b>Oct. 17, 1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Josephs</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Chews Landing N. J.</b>  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Robert E. Wilhelm</b>  |                         |  |   | ADDRESS<br><b>4308 Suitland Rd. Suitland Md.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>OCT 17 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>           |

1990

WFO: 22-61-26

508 1 130



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14928

14938

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) Beatrice Josephine Porter  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br>October 11 1968 |   |  | 2b. HOUR.<br>11:05 A.M.   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>April 11, 1889  |  | 6. AGE (In years last birthday)<br>79 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Massachusetts   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A..  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Prince George's Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Adelphi, Md.  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Hillhaven Nursing Home |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>School Teacher   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Public Sch.  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Silver Spring  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>8420 Navahoe Drive   |  | 14. FATHER'S NAME<br>First Middle Last<br>Cyrus Hibbard  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Florence Spear   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input checked="" type="checkbox"/> or unknown   |  | 16b. SOCIAL SECURITY NO.<br>214-60-6620  |  | 17. INFORMANT<br>Nursing Home Records   |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ANOTEMIA, UREMIA &amp; PNEUMONIA</u><br>1830 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1750</u><br>(b) <u>OBSTRUCTIVE UROPATHY &amp; CALCULI</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CARCINOMA OF UTERUS &amp; METASTASES</u><br>6 YRS<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3-4 weeks<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>PROTER, DISCERNOSIS &amp; GENERALIZED</u> |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 3, 1968</u> , to <u>OCT 11, 1968</u> , that (I) (we) last saw the deceased alive on <u>9/30, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Harold Stelling</u>   |  | DEGREE<br>M.D.   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br>10/11/68  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>HAROLD STELLING, MD  |  | 22e. ADDRESS<br>1352 UNIV BLVD E   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br>Oct. 12, 1968   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Fort Lincoln Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Colmar Manor Md                                |  |
| 24. FUNERAL DIRECTOR<br>Arthur Walters   |  | 25. ADDRESS<br>254 Carroll St. N.W.<br>Washington, D.C. 20012  |  | 25a. RECD BY REGISTRAR<br>DATE OCT 14 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>James J. Judge  |  |

MEDICAL CERTIFICATION

8321

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14

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14929

## CERTIFICATE OF DEATH

14939

|  |  |  |   |   |  |   |  |
|--|--|--|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>MARGERY Louise POWDERLY</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>OCT</b> Day <b>10</b> Year <b>68</b>    |   |  | 2b. HOUR-<br><b>9:35</b> M  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>  |   | 5. DATE OF BIRTH<br><b>10-19-1886</b>   |  | 6. AGE (In years lost birthday)<br><b>81</b> YRS.                       |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>PENNSYLVANIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>PRINCE GEORGE</b> Md.                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>HYATTSVILLE</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>CARROLL MANOR</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>REGISTERED NURSE (RETIRED)</b>                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md.</b> COUNTY <b>MONTGOMERY</b>  |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER<br><b>10102 Georgia Ave.</b>                     |  |
| 14. FATHER'S NAME First Middle Last<br><b>JOSEPH POWDERLY</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>CATHERINE LOFTUS</b> |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br><b>Yes, no, or unknown</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>577 07 1815</b>   |   | 17. INFORMANT Address<br><b>CARROLL MANOR RECORDS</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary infarct</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Atherosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hrs</b><br><b>3 years</b> |  |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4200</b>  |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?    |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                    |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>AUG 32, 1965</b> , to <b>Oct 10, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 9, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Thomas F Collins MD</b> DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |   | 22c. DATE SIGNED<br><b>Oct 10-68</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>THOMAS F COLLINS</b>  |  |  |   | 22e. ADDRESS<br><b>322-H OTNE.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>10-12-68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT OLIVET CEMETERY</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>WASHINGTON D.C.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Francis Collins 4748-Wine Ave. N.W.</b>   |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 14 1968</b> REGISTRAR'S SIGNATURE <b>John J. Jones</b>   |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10000

10000

10000

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
10M REV. 1/68

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14930

14940

|   |                         |   |   |  |   |
|---|-------------------------|---|---|--|---|
| 1. DECEASED-NAME<br>(Type or Print)<br>First Middle Last<br><b>Thomas LeRoy Proctor Jr.</b>   |                         |   | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br><b>10-17-68</b>  |  | 2b. HOUR<br>Minute<br><b>3:20pm</b>                           |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Negro</b> | 5. DATE OF BIRTH<br><b>8-9-1968</b>   | 6. AGE (in years lost birthday)<br>YRS. MONTHS DAYS<br><b>2 8</b>   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>10 17 68</b>  |   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.              |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)<br><b>Prince George Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>None</b> |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Prince George's</b>   | 13c. CITY OR TOWN<br><b>Clinton</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   | 13e. STREET AND NUMBER<br><b>8333 Old Alexander Ferry Rd.</b> |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Thomas L. Proctor</b>  |                         |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Mary G. Proctor</b>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |   | 17. INFORMANT<br><b>Thomas L. Proctor</b> ADDRESS<br><b>8333 Old Alex Ferry Clinton, Md., Rd.</b>      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral pneumonia, severe</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |                         |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                         |   |   |  |   |
| 19a. DATE OF OPERATION<br><b>490x</b>   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br><b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                        |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |   |   |  |   |
| ACTUAL SIGNATURE<br><b>John Kehoe MD</b>  |                         | EXAMINER'S NAME (Type)<br><b>John Kehoe MD</b>  |   | 22b. DATE SIGNED<br><b>10-18-68</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>10-21-68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Resurrection Cem.</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Rollins Funeral Home, Inc.</b>   |                         | 23d. LOCATION (City or Town) (County) (State)<br><b>Clinton, Maryland</b>                                     |   | 25a. REC'D BY REGISTRAR<br><b>OCT 22 1968</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |                         |   |   |  |   |

210001



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
10M REV. 1/68

14932

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14941

|  |                         |  |   |   |                                |   |   |  |
|--|-------------------------|--|---|---|--------------------------------|---|---|--|
| 1. DECEASED-NAME<br>(Type or Print)<br>First Middle Last<br><b>Thomas Hugh Quinn</b>   |                         |  | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br><b>10-11-68</b>                |   |                                | 2b. HOUR<br>12:30pm   |   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>10-2-1916</b>   | 6. AGE (in years lost birthday)<br><b>52</b> YRS.                           | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>10 11 68</b>                                   |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>BALT. MD</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mt. Rainier</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>4108 33rd. Street</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>PLUMBER</b>   |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CONSTRUCTION</b>  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE COUNTY<br><b>Maryland Prince George's</b>  |                         |  |   | 13c. CITY OR TOWN<br><b>Mt. Rainier</b>   |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>4108 33rd. Street</b>   |
| 14. FATHER'S NAME<br>First Middle Last<br><b>THOMAS P. QUINN</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>ADELAIDE S. MOLLMAN</b> |   |                                |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>YES</b>  |                         | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>WW2 579-10-4081</b>              |   | 17. INFORMANT<br>ADDRESS <b>329 LAUREL AVE</b><br><b>MARY QMALLONEE LAUREL, MD</b>  |                                |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>3rd degree burns 100% of body surface</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>890X</b>  |                         |  |   |   |                                |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>1160</b>  |                         |  |   |   |                                |   |   |  |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                           |   |                                |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br><b>12:30pm 10-11-68</b>                             |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Burned in house fire</b>  |                                |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>home</b>              |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>same as #13</b>  |                                |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |  |   |   |                                |   |   |  |
| ACTUAL SIGNATURE<br><b>John Kehoe</b>  |                         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                             |   |                                | 22b. DATE SIGNED<br><b>10-12-68</b>   |   |  |
| EXAMINER'S NAME (Type)<br><b>John Kehoe MD</b>   |                         |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                 |   |                                | ADDRESS (Street, city, town, or county)<br><b>Riverdale, Md.</b>                                |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 23b. DATE<br><b>10-15-68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>   |                                | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md</b>                            |   |  |
| 24. FUNERAL DIRECTOR<br><b>Doraldson Funeral Home Laurel Md</b>  |                         |  |   | ADDRESS<br><b>Laurel Md</b>   |                                | 25a. REC'D BY REGISTRAR<br><b>OCT 18 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b> |

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TO-HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be expected within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
30M REV. 1-68

| 14932  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  | 14942   |  |  |  |   |  |          |  |
|--|--|--|--|---|--|--|--|---|--|--|--|---|--|----------|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  | First   |  | Middle   |  | Last  |  | 2a. DATE OF DEATH  |  |   |  | 2b. HOUR |  |
| Baby Boy   |  |  |  | Rader   |  |  |  | Oct   |  | Month 5 Day 68   |  | Year 68   |  | 5:45AM   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |  |  | 6. AGE (In years<br>last birthday)                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.                  |  |          |  |
| Male   |  | Cauc.  |  | 10-05-68  |  |  |  | YRS.  |  |  |  | 2   |  |          |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |   |  |  |  | Md.   |  |          |  |
| Maryland   |  | U.S.A.   |  |   |  | Prince George's  |  |   |  |  |  |   |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)  |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |  |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |   |  |          |  |
| Cheverly   |  | Prince Georges Gen. Hosp.  |  |   |  |  |  |   |  |  |  |   |  |          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 13e. STREET AND NUMBER  |  |  |  |   |  |          |  |
| Md.  |  | Prince Georges   |  | Seat Pleasant   |  |  |  | 7009 A Street   |  |  |  |   |  |          |  |
| 14. FATHER'S NAME  |  | First  |  | Middle  |  | Last   |  | 15. MOTHER'S MAIDEN NAME  |  | First  |  | Middle  |  | Last     |  |
| James  |  | Russell  |  | Rader   |  |  |  | Sonja   |  | Kay  |  | Parker  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  |   |  |  |  | Address   |  |          |  |
|  |  |  |  |   |  |  |  |   |  |  |  |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |          |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Prematurity</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Same</u><br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |  |  |  |   |  |  |  |   |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |  |   |  |  |  |   |  |          |  |
| 776x   |  |  |  |   |  |  |  |   |  |  |  |   |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                 |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |  |  |   |  |          |  |
|  |  |  |  |   |  |  |  |   |  |  |  |   |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |  |  |   |  |          |  |
|  |  |  |  |   |  |  |  |   |  |  |  |   |  |          |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory,<br>office, building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |  |  |   |  |          |  |
|  |  |  |  |   |  |  |  |   |  |  |  |   |  |          |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>Oct. 5, 1968</u> , to <u>Oct. 5, 1968</u> , that (X) (we) lost<br>saw the deceased alive on <u>Oct. 5, 1968</u> , and that in (our) opinion death occurred on the date and hour and from the<br>causes stated above, (X) (we) did (not) view the body after death. |  |  |  |   |  |  |  |   |  |  |  |   |  |          |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  |   |  | 22d. PHYSICIAN'S<br>NAME (Type)  |  | 22e. ADDRESS  |  | 22f. MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/> |  | 22g. DATE SIGNED                                |  |          |  |
|  |  | Oct. 7, 1968   |  |   |  | Bernardo Alvarado, M. D.   |  | Prince Geo. Gen'l Hospital, Cheverly, Md.                               |  |  |  |   |  |          |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |   |  |  |  |   |  |          |  |
|  |  | 10/12/68   |  | Prince George's General   |  | Cheverly, Maryland   |  |   |  |  |  |   |  |          |  |
| 24. FUNERAL DIRECTOR   |  | 24b. ADDRESS   |  |   |  | 24c. DATED BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |          |  |
| Harry W. Penn, Jr.   |  | Administrator  |  |   |  | DATE OCT 15 1968   |  | J. Charles Judge  |  |  |  |   |  |          |  |

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U.S. DEPT. OF JUSTICE

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Item 18 film 406  
10-21-68 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14943

Item #13c, Film GLH0 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |  |   |   |   |   |              |  |  |   |  |
|--|--|--|---|---|---|---|--------------|--|--|---|--|
| 1. DECEASED-NAME<br>First Middle Last<br><b>Francis Simon Redmond</b>  |  |  | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br><b>10-8-68 1933</b>  |   |   | 2b. HOUR<br><b>3:30am</b>   |              |  |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>11-2-1903</b>  |   | 6. AGE (In years last birthday)<br><b>64</b> YRS.   |              | 7c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>10 8 68 19 3:52am</b>                                 |  |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                                 |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Prince George's</b>  |              |  | Md.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince George Hospital</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Federal A A</b> |              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U S Government</b> |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Prince George's</b>   |   |   | 13c. CITY OR TOWN<br><b>Glenn Dale</b>  |              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |  | 13e. STREET AND NUMBER<br><b>10013 Glenn Dale Rd., #T-2</b> |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Benjamin Redmond</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Margaret Carmody</b>                                      |   |   |   |              |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>no</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>220 42 2041</b>                       |   |   | 17. INFORMANT<br><b>Maxine C Redmond</b>  |              |  | ADDRESS<br><b>Lanham, Md.</b>                              |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>4129</b><br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic heart disease</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                      |  |  |   |   |   |   |              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>over 14 yrs!</b><br><b>5 yrs.</b> |  |   |  |
|  |  |  |   |   |   |   |              |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4200</b>   |  |  |   |   |   |   |              |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |   |              | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br><b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |              |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   |   | 21f. LOCATION Street or R.F.D. No.  |   | City or Town |  | County State   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |   |   |   |   |              |  |  |   |  |
| ACTUAL SIGNATURE<br><b>John Kehoe MD</b>   |  |  | M.D.  |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |              | 22b. DATE SIGNED<br><b>10-9-68</b>   |  |   |  |
| EXAMINER'S NAME (Type)<br><b>John Kehoe MD</b>   |  |  | Riverdale, Md.  |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |              | ADDRESS (Street, city, town, or county)  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>Oct 11, 1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Colmar Manor Pro Geo Md.</b>                              |              |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>F. Gasch's Sons Hyattsville, Md.</b>   |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE<br><b>OCT 14 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |              |  |  |   |  |

14943

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OCT 14 1968

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)  
30M REV. 1/68

| 14934  |  |  |  |  |              |  |      |  |   | 14944                           |  |  |  |                  |  |  |  |  |  |
|--|--|--|--|--|--------------|--|------|--|---|---------------------------------|--|--|--|------------------|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |              |  |      |  |   | CERTIFICATE OF DEATH            |  |  |  |                  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  |  | Middle       |  | Last |  |   | 2a. DATE OF DEATH               |  |  |  | 2b. HOUR         |  |  |  |  |  |
| Louis  |  |  | W.   |  | Redmond, Sr. |  |      | October 15 1968  |   |                                 |  | 5 P.M.                                       |  |                  |  |  |  |  |  |
| 3. SEX   |  |  | 4. RACE  |  |              | 5. DATE OF BIRTH   |      |  |   | 6. AGE (In years lost birthday) |  | IF UNDER 1 YEAR                              |  | IF UNDER 24 HRS. |  |  |  |  |  |
| Male   |  |  | White  |  |              | 12/4/1888  |      |  |   | 79 YRS.                         |  | MONTHS DAYS                                  |  | HOURS MIN.       |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      |  | 9. COUNTY OF DEATH  |                                 |  |  |  |                  |  |  |  |  |  |
| Maryland   |  |  | U.S.A.   |  |              |  |      |  | Prince Georges Md.  |                                 |  |  |  |                  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |              |  |      |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |                  |  |  |  |  |  |
| Glenn Dale   |  |  | Glenn Dale Hospital  |  |              |  |      |  | Retired   |                                 |  | Florist                                      |  |                  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |              | 13c. CITY OR TOWN  |      | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER          |  |  |  |                  |  |  |  |  |  |
| D.C.   |  |  |  |  |              | Washington   |      |  |   | 51 Todd Place, N.E.             |  |  |  |                  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |              |  |      |  |   |                                 |  |  |  |                  |  |  |  |  |  |
| First Middle Last  |  |  | First Middle Last  |  |              |  |      |  |   |                                 |  |  |  |                  |  |  |  |  |  |
| James E. Redmond   |  |  | Mary Summers   |  |              |  |      |  |   |                                 |  |  |  |                  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |  |              | 17. INFORMANT  |      |  | Address   |                                 |  |  |  |                  |  |  |  |  |  |
| No   |  |  | 577-07-8839  |  |              | X Deceased   |      |  | Louis W. Redmond, Jr. 3408 55th Ave. Cheverly, Md.                                      |                                 |  |  |  |                  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |              |  |      |  |   |                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |              |  |      |  |   |                                 |  |  |  |                  |  |  |  |  |  |
| IMMEDIATE CAUSE (a)  |  |  |  |  |              |  |      |  |   |                                 |  | 4 days                                       |  |                  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |              |  |      |  |   |                                 |  |  |  |                  |  |  |  |  |  |
| Pulmonary emphysema & respiratory insufficiency  |  |  |  |  |              |  |      |  |   |                                 |  | years  |  |                  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |              |  |      |  |   |                                 |  |  |  |                  |  |  |  |  |  |
| Pulmonary tuberculosis   |  |  |  |  |              |  |      |  |   |                                 |  | 6 years                                      |  |                  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |              |  |      |  |   |                                 |  |  |  |                  |  |  |  |  |  |
| Arteriosclerotic heart disease with myocardial infarction (1962)   |  |  |  |  |              |  |      |  |   |                                 |  |  |  |                  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |              | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |      |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes                |                                 |  |  |  |                  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |      |  |   |                                 |  |  |  |                  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |              | 21f. LOCATION Street or R.F.D. No. City or Town County State   |      |  |   |                                 |  |  |  |                  |  |  |  |  |  |
| 22a. I certify that (it) (this hospital) attended the deceased from 10/11/1968, to 10/15/1968, that (it) (we) last saw the deceased alive on 10/15/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (it) (we) (did) (did not) view the body after death. |  |  |  |  |              |  |      |  |   |                                 |  |  |  |                  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  | DEGREE   |  |              | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |      |  | 22c. DATE SIGNED 10/15/1968   |                                 |  |  |  |                  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  | 22e. ADDRESS   |  |              |  |      |  |   |                                 |  |  |  |                  |  |  |  |  |  |
| Moe Weiss, M.D.  |  |  | Glenn Dale Hospital  |  |              | Glenn Dale, Maryland   |      |  |   |                                 |  |  |  |                  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  | 23b. DATE  |  |              | 23c. NAME OF CEMETERY OR CREMATORY   |      |  | 23d. LOCATION (City or Town) (County) (State)   |                                 |  |  |  |                  |  |  |  |  |  |
| Burial   |  |  | 10-18-1968   |  |              | Prospect Hill Cemetery   |      |  | Washington, D. C.   |                                 |  |  |  |                  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  | ADDRESS  |  |              | 25a. REC'D BY REGISTRAR  |      |  | 25b. REGISTRAR'S SIGNATURE  |                                 |  |  |  |                  |  |  |  |  |  |
| C. Glen Carter   |  |  | Sil. Spr.  |  |              | DATE OCT 21 1968   |      |  | Charles Judge   |                                 |  |  |  |                  |  |  |  |  |  |
| Warner E. Pumphrey, Inc. 8434 Ga. Ave.   |  |  | Md.  |  |              |  |      |  |   |                                 |  |  |  |                  |  |  |  |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (30M REV. 1-68)

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                              |  |   |   |  |   |  |  |
|--|--|------------------------------|--|---|---|--|---|--|--|
| CERTIFICATE OF DEATH   |  |                              |  |   |   |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |                              | First Middle Last  |   |   | 2a. DATE OF DEATH<br>Month Day Year  |   |  | 2b. HOUR                                     |
| Charles T. Richards  |  |                              |  |   |   | Oct. 30, 1968  |   |  | 11:07 P.M.                                   |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH  |   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS               |
| Male   |  | Caucasian                    |  | Jan. 29-1893  |   |  | XXK75 YRS.  |  | IF UNDER 24 HRS.<br>HOURS MIN.               |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |   |  |  |
| Maryland   |  | USA                          |  |   |   | Prince George's Md.  |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Cheverly   |  |                              | DOA Prince Geo. Gen'l Hospital   |   |   | Retired Wash. Gas Co.  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN                               |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |
| Maryland   |  |                              | Prince George's  |   | Mt. Rainier                                     |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  | 3414 Newton Street                           |
| 14. FATHER'S NAME First Middle Last  |  |                              | 15. MOTHER'S MAIDEN NAME First Middle Last   |   |   |  |   |  |  |
| JOHN F. Richards   |  |                              | Ella Seiger  |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown   |  |                              | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address                           |  |   |  |  |
| No   |  |                              |  |   | John F. Richards- 3314- Boones Lane Wash/28. DC |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Coronary Occlusion with Myocardial Infarction.<br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                              |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |                              |  |   |   |  |   |  |  |
| 4201   |  |                              |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)        |   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                           |   |  |  |
| 22a. I certify that (I) (the physician) attended the deceased from Oct 7, 1968, to Oct. 30, 1968, that (I) (we) last saw the deceased alive on Oct. 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |                              |  |   |   |  |   |  |  |
| 22b. SIGNATURE Oliver B. Bond M.D.   |  |                              | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   |   | 22c. DATE SIGNED Oct. 30, 1968   |   |  |  |
| 22d. PHYSICIAN'S NAME (Type) OLIVER B. BOND M.D.   |  |                              | 22e. ADDRESS 6872 RIVERDALE ROAD LANHAM MARYLAND 20801   |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY              |  | 23d. LOCATION (City or Town) (County) (State)                                     |  |  |
| Burial   |  |                              | Nov. 2-68  |   | Cedar Hill Cemetery                             |  | Suitland, Maryland  |  |  |
| 24. FUNERAL DIRECTOR   |  |                              | ADDRESS  |   |   | 24a. RECEIVED BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |  |
| Simmons Bros.  |  |                              | 1661-Gd. Hope Rd. S.E.   |   |   | NOV 4 1968   |   | Charles Judge  |  |

6661

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14936

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 5 Film 405 101668  
CERTIFICATE OF DEATH

14946

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)   |  | First <u>Jacquelyn</u> Middle <u>J.</u> Last <u>Richardson</u>  |  | 2a. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>7</u> Year <u>1968</u>   |  | 2b. HOUR<br><u>4:20PM</u>   |  |
| 3. SEX<br><u>Female</u>   |  | 4. RACE<br><u>Caucasian</u>   |  | 5. DATE OF BIRTH<br><u>12-30-31 1930</u>   |  | 6. AGE (In years last birthday)<br><u>37</u> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U S A</u>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><u>Prince George's</u> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Cheverly</u>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>Prince Geo. Gen'l Hospital</u> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><u>none</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><u>Maryland</u>  |  | 13b. CITY OR TOWN<br><u>Prince George's Upper Marlboro</u>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER<br><u>7711 Old Forestville Rd. Marlboro Pike</u>                   |  |
| 14. FATHER'S NAME First <u>Harry</u> Middle <u>Richardson</u> Last  |  | 15. MOTHER'S MAIDEN NAME First <u>Martha</u> Middle <u>Klotz</u> Last   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <u>No</u>  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address <u>Rd.</u><br><u>Martha R. Richardson 7711 Old Forestville</u>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>UREMIA</u><br><u>5932</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>CHRONIC RENAL INSUFF.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                   |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>603 X</u>  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <u>19</u>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |
| 22a. I certify that <u>he</u> (this hospital) attended the deceased from <u>Oct. 6,</u> 19 <u>68</u> , to <u>Oct. 7,</u> 19 <u>68</u> , that <u>he</u> (we) last saw the deceased alive on <u>Oct. 7,</u> 19 <u>68</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>he</u> (we) (did) <u>not</u> view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>R B Ingham</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |   |  |  |  | 22c. DATE SIGNED<br><u>Oct. 8, 1968</u>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Roger B. Ingham, M. D.</u>   |  |   |  | 22e. ADDRESS<br><u>Prince George's Gen'l Hospital, Cheverly,</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE<br><u>10-10-68</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Epiphany Church Cemetery</u>  |  | 23d. LOCATION (City or Town) (County) <u>Maryland</u><br><u>Forestville, Md. Pr. Geo.</u> |  |
| 24. FUNERAL DIRECTOR<br><u>Wilhelm Funeral Home 4308 Suitland Rd. S. E.</u>   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>OCT 11 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>f Charles Judge</u>                                      |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |  |  |  |                                   |  |
|---|--|--|--|--|--|--|--|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |                                   |  |
| 14937   |  |  |  |  | 14947  |  |  |  |                                   |  |
| 1. DECEASED-NAME (Type or print)  |  |  |  |  | 2a. DATE OF DEATH  |  |  | 2b. HOUR                                     |                                   |  |
| Paul Rayfield Riddlemoser   |  |  |  |  | 10 Month 8 Day 68 Year   |  |  | 6:25 PM                                      |                                   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (In years last birthday)                                      |  | IF UNDER 1 YEAR MONTHS DAYS       |  |
| Male  |  | White  |  | 9-23-89  |  |  | 9 YRS.   |  | IF UNDER 24 HRS. HOURS MIN.       |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |                                   |  |
| Maryland  |  | USA  |  |  |  | Prince George's Md.  |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Riverdale, Md.  |  |  | Leland Memorial Hosp.  |  |  | Salesman   |  |  | Packing Co.                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE   |  |  | 13b. COUNTY  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |                                   |  |
| Md.   |  |  | Prince George's  |  |  |  |  | Rt. #1 Box 304 A.                            |                                   |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |                                   |  |
| George Riddlemoser  |  |  |  |  |  |  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT Address  |  |  |                                   |  |
|   |  |  | 216-07-1594  |  |  | Paul W Riddlemoser Laurel Md.  |  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                   |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 RENEAL FAILURE  |  |  |  |  |  |  |  | 1 DAY  |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE  |  |  |  |  |  |  |  | 1 WEEK                                       |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC C-V DISEASE   |  |  |  |  |  |  |  | UNKNOWN                                      |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |                                   |  |
| 4221  |  |  |  |  |  |  |  |  |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                   |  |
|   |  |  |  |  |  |  |  |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |                                   |  |
|   |  |  |  |  |  |  |  |  |                                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |                                   |  |
|   |  |  |  |  |  |  |  |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 22 SEP, 1968, to 8 OCT, 1968, that (I) (we) last saw the deceased alive on 8 OCT, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |                                   |  |
| 22b. SIGNATURE C.J. Houmann   |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED 8 OCT 1968  |  |                                   |  |
| 22d. PHYSICIAN'S NAME (Type) C.J. HOUMANN   |  |  |  |  | 22e. ADDRESS RIVERDALE MD.   |  |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE 10/11/68   |  | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln  |  | 23d. LOCATION (City or Town) (County) (State) Colmar Manor PG Md                             |  |  |                                   |  |
| 24. FUNERAL DIRECTOR De Witt Donaldson Laurel, Md   |  |  |  |  | 25a. REC'D BY REGISTRAR DATE OCT 14 1968   |  | 25b. REGISTRAR'S SIGNATURE   |  |                                   |  |

1992

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

[illegible]

2007 503,552.00

928046-1553

5.000

5-70-522

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |                  |   |                 |      |  |      |                          |   |          |  |
|---|---------|------------------|---|-----------------|------|--|------|--------------------------|---|----------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |                  |   |                 |      |  |      |                          |   |          |  |
| 1. DECEASED-NAME<br>(Type or Print)   |         |                  | First Middle Last   |                 |      | 20. DATE KNOWN OF DEATH  |      |                          | 2b. HOUR  |          |  |
| Hollie  |         |                  | Roberson  |                 |      | Month Day Year   |      |                          | 10-19-68 1910:45pm  |          |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years last birthday)   | IF UNDER 1 YEAR |      | IF UNDER 24 HRS  |      | 2c. DATE PRONOUNCED DEAD |   | 2d. HOUR |  |
| Male  | Negro   | 6-3-1913         | 55 YRS.   | MONTHS          | DAYS | HOURS  | MIN. | Month Day Year           | 10 19 68 10:45pm  |          |  |
| 7a. BIRTHPLACE (State or foreign country)   |         |                  | 7b. CITIZEN OF WHAT COUNTRY?  |                 |      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |                          | 9. COUNTY OF DEATH  |          |  |
| South Carolina  |         |                  | USA   |                 |      |  |      |                          | Prince George's Md.   |          |  |
| 10. CITY OR TOWN OF DEATH   |         |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  |                 |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |      |                          | 12b. KIND OF BUSINESS OR INDUSTRY   |          |  |
| Cheverly  |         |                  | Prince George Hospital  |                 |      | Custodial  |      |                          |   |          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                  | 13b. COUNTY   |                 |      | 13c. CITY OR TOWN  |      |                          | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |          |  |
| Maryland  |         |                  | Prince George's   |                 |      | Coral Hills  |      |                          | 1410 Boones Hill Rd.  |          |  |
| 14. FATHER'S NAME   |         |                  | 15. MOTHER'S MAIDEN NAME  |                 |      | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |      |                          | 16b. SOCIAL SECURITY NO.  |          |  |
| John H. Roberson  |         |                  | Georgie A. Adams  |                 |      | No   |      |                          |   |          |  |
| 17. INFORMANT   |         |                  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> (b) <u>Pulmonary tuberculosis</u> (c) <u></u> |                 |      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |      |                          | 1 week  |          |  |
| Georgie A. Peterson daughter  |         |                  | Ave., S.E.  |                 |      | 1306 S.C.  |      |                          | over 1 yr.  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |                  |   |                 |      |  |      |                          |   |          |  |
| 19a. DATE OF OPERATION  |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                 |      | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |      |                          |   |          |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |                  | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.   |                 |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |      |                          |   |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |         |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |                 |      | 21f. LOCATION Street or R.F.D. No. City or Town County State   |      |                          |   |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                  |   |                 |      |  |      |                          |   |          |  |
| ACTUAL SIGNATURE  |         |                  | CHIEF MEDICAL EXAMINER  |                 |      | 22b. DATE SIGNED   |      |                          |   |          |  |
| EXAMINER'S NAME (Type)  |         |                  | DEPUTY MEDICAL EXAMINER   |                 |      | 10-20-68   |      |                          |   |          |  |
| John Kehoe MD   |         |                  | Riverdale, Md.  |                 |      |  |      |                          |   |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |                  | 23b. DATE   |                 |      | 23c. NAME OF CEMETERY OR CREMATORY   |      |                          | 23d. LOCATION (City or Town) (County) (State)                                     |          |  |
| Burial  |         |                  | 10/25/68  |                 |      |  |      |                          | Edgefield, South Carolina   |          |  |
| 24. FUNERAL DIRECTOR  |         |                  | 25a. REC'D BY REGISTRAR   |                 |      | 25b. REGISTRAR'S SIGNATURE   |      |                          |   |          |  |
| Stewart Funeral Home  |         |                  | 4001 Benning Rd., N.E.  |                 |      | OCT 25 1968  |      |                          | Charles Judge   |          |  |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14939

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14949

|   |                         |   |   |   |                                |   |                                |  |
|---|-------------------------|---|---|---|--------------------------------|---|--------------------------------|--|
| 1. DECEASED NAME (Type or Print)<br><b>Alan Francis Robins</b>  |                         |   | 2a. DATE KNOWN OF ESTIMATED DEATH<br><input checked="" type="checkbox"/> 10/18/68 19 <b>8:20A</b> M |   |                                | 2b. HOUR  |                                |  |
| 3. SEX<br><b>male</b>   | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br><b>1/6/1928</b>   | 6. AGE (In years last birthday)<br><b>40</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Washington D C</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>           |                                | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.  |                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lewisdale</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Driveway of 6640 23rd ave.</b> |   |   |                                | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Electrician</b> |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md</b>  |                         | 13b. COUNTY<br><b>Pro Geo</b>   |   | 13c. CITY OR TOWN<br><b>Lanham</b>  |                                | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO               |                                | 13e. STREET AND NUMBER<br><b>6884 Riverdale, Road.</b> |
| 14. FATHER'S NAME First Middle Last<br><b>Thomas D Robins</b>   |                         |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Marjorie Denslow</b>                               |   |                                |   |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>yes</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>W W 11</b>   |   | 17. INFORMANT<br><b>Thomas D Robins</b>   |                                | ADDRESS<br><b>Lanham, Md.</b>   |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>955X</b><br>IMMEDIATE CAUSE (a) <b>Gun shot wound of head</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                         |   |   |   |                                |   |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)<br><b>976X</b>  |                         |   |   |   |                                |   |                                |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |                                | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |                                |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br><b>8:20A P.M. 10/18/68</b>                                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Shot self in head with 12 gauge shot gun.</b>                                   |                                |   |                                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Driveway of 6640 23rd ave</b>  |   | 21f. LOCATION Street or R.F.D. No.<br><b>Lewisdale</b>  |                                | City or Town<br><b>Prince George's</b>  |                                | State<br><b>Maryland</b>                               |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |   |   |   |                                |   |                                |  |
| ACTUAL SIGNATURE<br><b>John Kehoe</b>   |                         | EXAMINER'S NAME (Type)<br><b>John Kehoe MD</b>  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |                                | 22b. DATE SIGNED<br><b>10/18/68</b>   |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>10/21/68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln Cemetery</b>  |                                | 23d. LOCATION (City or Town) (County) (State)<br><b>Colmar Manor Pro Geo Md.</b>                              |                                |  |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b>  |                         |   |   | ADDRESS<br><b>Hyattsville, Md.</b>  |                                | 25a. REC'D BY REGISTRAR<br>DATE<br><b>OCT 22 1968</b>   |                                | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>     |

2524

9801 S 2730



**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~remove~~ return carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

|   |  |                              |  |   |  |   |                                 |  |   |  |  |
|---|--|------------------------------|--|---|--|---|---------------------------------|--|---|--|--|
| <div style="display: flex; justify-content: space-between;"> <span>14940</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> </div> <div style="display: flex; justify-content: space-between;"> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>14950</span> </div>   |  |                              |  |   |  |   |                                 |  |   |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>Item#5,6, Film#406 11/20/68 km</span> <span>CERTIFICATE OF DEATH</span> </div>   |  |                              |  |   |  |   |                                 |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |                              |  |   | 2a. DATE OF DEATH  |   |                                 | 2b. HOUR   |   |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>First</span> <span>Middle</span> <span>Last</span> </div> <div style="display: flex; justify-content: space-between;"> <span>Adolph</span> <span>Rodenhauser</span> </div>   |  |                              |  |   | <div style="display: flex; justify-content: space-between;"> <span>Month</span> <span>Day</span> <span>Year</span> </div> <div style="display: flex; justify-content: space-between;"> <span>Oct.</span> <span>8</span> <span>1968</span> </div> |   |                                 | <div style="display: flex; justify-content: space-between;"> <span>4</span> <span>15AM</span> </div> |   |  |  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH  |  |   | 6. AGE (In years last birthday) |  | IF UNDER 1 YEAR<br>MONTHS   DAYS   HOURS   MIN. |  |  |
| Male  |  | White                        |  | January 27, 1905<br><del>xxxxxx</del>   |  |   | 63 YRS.                         |  |   |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  | 9. COUNTY OF DEATH  |                                 |  |   |  |  |
| New York  |  | U. S. A.                     |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | Pr. Geo., Md.   |                                 |  |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY               |  |  |
| Cheverly  |  |                              | Pr. Geo., Gen. Hosp.,  |   |  | (Fireman) Retired   |                                 |  | Hospital  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |                              | 13b. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET AND NUMBER          |  |   |  |  |
| Maryland  |  |                              | Pr. Geo.,  |   | xxx  |   | 5519 Belva St.                  |  |   |  |  |
| 14. FATHER'S NAME   |  |                              |  | 15. MOTHER'S MAIDEN NAME  |  |   |                                 |  |   |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>First</span> <span>Middle</span> <span>Last</span> </div> <div style="display: flex; justify-content: space-between;"> <span>Peter</span> <span>-- Rodenhauser</span> </div>   |  |                              |  | <div style="display: flex; justify-content: space-between;"> <span>First</span> <span>Middle</span> <span>Last</span> </div> <div style="display: flex; justify-content: space-between;"> <span>Margaretha</span> <span>-- Voll</span> </div> |  |   |                                 |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |  |                              |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |                                 |  |   |  |  |
| No  |  |                              |  |   |  | Address Same as Items 13a-13c<br>Anneliese M. Rodenhauser-                              |                                 |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                              |  |   |  |   |                                 |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Hypertrophy, severe, (750)grms.</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>with heart failure.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |                              |  |   |  |   |                                 |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |                              |  |   |  |   |                                 |  |   |  |  |
| 4222  |  |                              |  |   |  |   |                                 |  |   |  |  |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  | 20a. AUTOPSY?   |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                 |   |  |  |
| Oct. 4, 1968  |  |                              | Obstruction of Intestine   |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |                                 | Yes  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |                              | 21b. TIME OF INJURY<br>HOUR A.M.   Month   Day   Year<br>P.M.   19           |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |                                 |  |   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |  | 21f. LOCATION Street or R.F.D. No.  |                                 |  | City or Town   County   State                   |  |  |
| 22a. I certify that (I) <del>(did not)</del> attended the deceased from <u>7-1</u> , 19 <u>68</u> , to <u>Oct. 8</u> , 19 <u>68</u> , that (I) <del>(saw)</del> last saw the deceased alive on <u>Oct. 8</u> , 19 <u>68</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(did)</del> (did not) view the body after death. |  |                              |  |   |  |   |                                 |  |   |  |  |
| 22b. SIGNATURE  |  |                              |  |   |  | 22c. DATE SIGNED  |                                 |  |   |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>DEGREE</span> <span>ATTENDING PHYS.</span> <span>MED. DIRECTOR</span> <span>STAFF PHYS.</span> </div> <div style="display: flex; justify-content: space-between;"> <span></span> <span></span> <span><input checked="" type="checkbox"/></span> <span><input type="checkbox"/></span> </div>   |  |                              |  |   |  | 10-9-68   |                                 |  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |                              |  |   |  | 22e. ADDRESS  |                                 |  |   |  |  |
| Aaron Deitz, M. D.  |  |                              |  |   |  | Prince George's Plaza, Hyattsville, Md.   |                                 |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |   |                                 | 23d. LOCATION (City or Town) (County) (State)  |   |  |  |
| Cremation   |  |                              | 10/10/68   |   | Cedar Hill Crematory   |   |                                 | Suitland PrGeo. Md.  |   |  |  |
| 24. FUNERAL DIRECTOR  |  |                              |  |   |  | 25a. REC'D BY REGISTRAR   |                                 |  | 25b. REGISTRAR'S SIGNATURE                      |  |  |
| Ritchie Bros. Fun'l Home -  |  |                              |  |   |  | Upper Marlboro, Md.   |                                 |  | DATE OCT 14 1968<br>Charles Judge               |  |  |

2024

30

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14942

CERTIFICATE OF DEATH

14951

|   |                                  |   |   |   |  |   |                                    |
|---|----------------------------------|---|---|---|--|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> |  |   |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>College Park</b>   |                                  |   | c. LENGTH OF STAY IN 1b<br><b>Hours</b> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Riverdale</b> |   |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>9714 51st Avenue</b>   |                                  |   |   | d. STREET ADDRESS<br><b>6310 51st Avenue</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                    |
| 3. NAME OF DECEASED (Type or print)<br><b>Edna Florence Rogers</b>  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>16</b> Year <b>19 68</b>  |  |   |                                    |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1/23/1896</b>    |   | 9. AGE (In years last birthday)<br><b>72</b> yrs.  | IF UNDER 1 YEAR<br>Months   | IF UNDER 24 HRS.<br>Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Virginia</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                    |
| 13. FATHER'S NAME<br><b>Trenton Turner</b>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Ella Hitt</b>  |  |   |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>577054310B</b>  |   | 17. INFORMANT Address<br><b>Andrew C Rogers same as above</b>   |  |   |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>188X HYPOSTATIC PNEUMONIA</b><br>DUE TO (b) <b>CARCINOMA ABDOMINAL</b><br>DUE TO (c) <b>CARCINOMA BLADDER</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>2 yrs</b><br><b>2 yrs</b>                 |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>1810</b>   |                                  |   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Sept 10, 1968</b> , to <b>Oct 15, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 15, 1968</b> , and that death occurred at <b>3 A.M.</b> from causes and on the date stated above.   |                                  |   |   |   |  |   |                                    |
| 22a. SIGNATURE<br><b>Richard F. Shaw</b>  |                                  |   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>              |  | 22b. DATE SIGNED<br><b>Oct 16 1968</b>  |                                    |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DR RICHARD F. SHAW</b>   |                                  |   |   | 22d. ADDRESS<br><b>1324 - Michigan Ave. NE</b>  |  |   |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>10/19/1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cemetery Colmar Manor Maryland</b>  |  | 23d. LOCATION (City or Town) (County) (State)   |                                    |
| 24. FUNERAL DIRECTOR<br><b>Nalley's Funeral Home Mt. Rainier, Md.</b>   |                                  |   |   | 25a. REC'D BY REGISTRAR<br><b>OCT 18 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |                                    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14881

STATE OF TEXAS

1901

24  
2  
2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14942

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14952

|   |  |  |  |   |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Lucy</b>   |  | First  |  | Middle  |  | Last  |  | 2a. DATE OF DEATH<br>Month <b>10</b> Day <b>14</b> Year <b>68</b>                       |  | 2b. HOUR<br><b>2:35</b> P.M.                                     |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Negro</b>  |  | 5. DATE OF BIRTH<br><b>6-18-1890</b>  |  |   |  | 6. AGE (In years last birthday)<br><b>78</b> YRS.                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hyattsville</b>   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>6500 Riggs Rd. Hyattsville</b>   |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>D.C.</b>   |  |  |  | 13b. COUNTY<br><b>Washington</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>4926 3rd St. N.W.</b>                                      |  |  |  |
| 14. FATHER'S NAME<br>First <b>Archie</b> Middle <b>BERRY</b> Last   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>SARAH</b> Middle Last  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>571-01-9469</b>  |  | 17. INFORMANT<br>Address<br><b>Daughter - Earlene Miser - 4926 3rd St. N.W.</b>                 |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br><b>4379</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>337X</b><br>(b) <b>Generalized Cerebral arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Cerebral Vascular Accident</b> |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                    |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-6</b> , 19 <b>67</b> , to <b>10-14</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-14</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Elmer Rones</b>  |  | M.D. DEGREE <input checked="" type="checkbox"/>                              |  | MED. DIRECTOR <input type="checkbox"/>  |  | STAFF PHYS. <input type="checkbox"/>  |  | 22c. DATE SIGNED<br><b>10-14-68</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS<br><b>3201 0 St. S.E.</b>                                       |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify)  |  | 23b. DATE<br><b>10/18/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harmony Memorial Park</b>  |  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Maryland</b>                        |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John T. Stewart</b>  |  | ADDRESS<br><b>Stewart Funeral Home-4001 Benning Rd.</b>                      |  | 25a. REC'D BY REGISTRAR<br><b>OCT 17 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |  |  |  |

1955

1955

1955





14943

CERTIFICATE OF DEATH

14953

|   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |
|---|--|--|---|--|--|--|--|--|--|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Timothy</b>  |  |  | First Middle Lost   |  |  | 2a. DATE OF DEATH<br>Month <b>Oct</b> Day <b>7</b> Year <b>68</b>  |  |  | 2b. HOUR<br><b>8:30</b> AM   |  |  |   |  |  |
| 3. SEX<br><b>MALE</b>   |  |  | 4. RACE<br><b>CAUCASIAN</b>   |  |  | 5. DATE OF BIRTH<br><b>6 JUNE 1968</b>   |  |  | 6. AGE (In years last birthday)<br><b>4</b> YRS.   |  |  |   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>PUERTO RICO</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>PRINCE George's County Md.</b>                                      |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>ANDREW AFB</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>MALCOLM GROW USAF HOSP</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>NA</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NA</b>   |  |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>PUERTO RICO</b>   |  |  | 13b. COUNTY<br><b>Ramey AFB</b>   |  |  | 13c. CITY OR TOWN<br><b>Ramey AFB</b>  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>117 W. STREET</b>                          |  |  |
| 14. FATHER'S NAME<br>First Middle Lost<br><b>CHARLES ALTON ROMAN</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Lost<br><b>CHRISTINE LENA BRIGIDA</b>                                |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)<br><b>NO</b>                                    |  |  | 16b. SOCIAL SECURITY NO.<br><b>NA</b>  |  |  | 17. INFORMANT<br><b>FATHER</b> Address<br><b>117 W. ST. PUERTO RICO</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br><b>7473</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>pulmonary atresia &amp; pulmonary hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 d. 3 mo</b> |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>7590 Sepsis</b>  |  |  |   |  |  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>30 Aug</b> , 19 <b>68</b> , to <b>8 Oct</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>27 Oct</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>R.H. Hintz</b> <b>MO</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |   |  |  |  |  |  | 22c. DATE SIGNED<br><b>8 Oct 68</b>  |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>RAYMOND HINTZ, CAPT.</b>   |  |  |   |  |  |  |  |  | 22e. ADDRESS<br><b>MALCOLM GROW USAF Hosp Andrews</b>  |  |  |   |  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>10-8-68</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Long Island Mall Cm.</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Farmington Long Island N.Y.</b>          |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>W. W. Chamber</b> ADDRESS<br><b>577-11 St. S.E.</b>  |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 10 1968</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |  |  |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14328

14328



OCT 10 1938

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

14944

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14954

|  |         |  |                  |  |                                 |  |                        |  |       |
|--|---------|--|------------------|--|---------------------------------|--|------------------------|--|-------|
| 1. DECEASED-NAME<br>(Type or print)  |         | First  | Middle           | Lost   | 2a. DATE OF DEATH               |  | 2b. HOUR               |  |       |
| Nathan   |         | H.   |                  | Rose   | October 15 1968                 |  | 9:00 P.M.              |  |       |
| 3. SEX   | 4. RACE |  | 5. DATE OF BIRTH |  | 6. AGE (In years lost birthday) |  | IF UNDER 1 YEAR        |  |       |
| Male   | White   |  | May 19, 1909     |  | 59 YRS.                         |  | MONTHS DAYS HOURS MIN. |  |       |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9. COUNTY OF DEATH   |                        |  |       |
| New York   |         | U.S.A.   |                  |  |                                 | Prince George Md.  |                        |  |       |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |                                 | 12b. KIND OF BUSINESS OR INDUSTRY  |                        |  |       |
| Oxon Hill, Md.   |         | 1107 Palmer Rd., Oxon Hill   |                  | Sheet Metal Wk.  |                                 |  |                        |  |       |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         | 13b. COUNTY  |                  | 13c. CITY OR TOWN  |                                 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                        | 13e. STREET AND NUMBER                       |       |
| Md.  |         | Prince George  |                  | Oxon Hill  |                                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                        | 1107 Palmer Rd.                              |       |
| 14. FATHER'S NAME  |         | First  | Middle           | Lost   | 15. MOTHER'S MAIDEN NAME        |  | First                  | Middle                                       | Lost  |
| Sam Rose   |         |  |                  |  | Dora Cooper                     |  |                        |  |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |         | 16b. SOCIAL SECURITY NO.   |                  | 17. INFORMANT  |                                 | Address  |                        |  |       |
| No   |         | 066-01-0128  |                  | Mrs. Charles Ettinger  |                                 | Washington, D.C. 9603 Cleveland Lane   |                        |  |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |                  |  |                                 |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |       |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction  |         |  |                  |  |                                 |  |                        | 1 Day  |       |
| 4109 DUE TO, OR AS A CONSEQUENCE OF  |         |  |                  |  |                                 |  |                        |  |       |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |         |  |                  |  |                                 |  |                        | Generalized Atherosclerosis Years            |       |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |         |  |                  |  |                                 |  |                        |  |       |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |         |  |                  |  |                                 |  |                        |  |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |  |                  |  |                                 |  |                        |  |       |
| 4201   |         |  |                  |  |                                 |  |                        |  |       |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                        |  |       |
|  |         |  |                  |  |                                 |  |                        |  |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |         | 21b. TIME OF INJURY HOUR A.M. Month Day Year                                 |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                                 |  |                        |  |       |
|  |         | 19   |                  |  |                                 |  |                        |  |       |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  | 21f. LOCATION Street or R.F.D. No.   |                                 | City or Town   |                        | County                                       | State |
|  |         |  |                  |  |                                 |  |                        |  |       |
| 22a. I certify that (this hospital) attended the deceased from 3-14, 19 66, to 10-15, 19 68, that (we) last saw the deceased alive on 10-15, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         |  |                  |  |                                 |  |                        |  |       |
| 22b. SIGNATURE   |         | 22c. DATE SIGNED   |                  |  |                                 |  |                        |  |       |
| Richard H. Dobson, M.D.  |         | 10/15/68   |                  |  |                                 |  |                        |  |       |
| 22d. PHYSICIAN'S NAME (Type)   |         | 22e. ADDRESS   |                  |  |                                 |  |                        |  |       |
| Richard H. Dobson, M.D.  |         | Brandywine, Maryland 20613   |                  |  |                                 |  |                        |  |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY   |                                 | 23d. LOCATION (City or Town) (County) (State)  |                        |  |       |
| Burial   |         | 10/17/68   |                  | King David Cemetery  |                                 | Falls Church, Virginia   |                        |  |       |
| 24. FUNERAL DIRECTOR   |         | 25a. REC'D BY REGISTRAR  |                  | 25b. REGISTRAR'S SIGNATURE   |                                 |  |                        |  |       |
| The Demaine Funeral Homes, Inc.  |         | OCT 21 1968  |                  | Charles Judge  |                                 |  |                        |  |       |

14826

14826

14826

October 12 1968

Male White 10/12/68

Prison George

1107 Palmer St. Oxon Hill, Md.

Prison George Oxon Hill, Md.

Dora Cooper

Washington, D.C. 000-01-0128 Mrs. Charles Stinger, 8003 Cleveland Lane

1 day Vocational Institution

Generalized Atrophies

10-12 3-11 66 10-12 66

10/12/68 X

Alzheimer's Disease

10/17/68 King David Cemetery Falls Church, Virginia

Oct 21 1968

The Denning Funeral Home, Inc. Alexandria, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and capably filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |   |   |   |  |  |  |  |
|---|--|--|---|---|---|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |   |   |   |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |   |   |   |   |  |  |  |  |
| 14845   |  | 14955  |   |   |   |   |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>George M. Rountree</b>   |  |  |   |   | 2a. DATE OF DEATH Month Day Year<br><b>Oct. 22, 1968</b>                          |   |  | 2b. HOUR<br><b>1 P. M.</b>                                 |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH<br><b>1898</b>   |   | 6. AGE (In years lost birthday)<br><b>70</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>GEORGIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince Geo. Gen'l Hospital</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>GROCERY CLERK</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GIANT Food Co</b>  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Prince George's</b>   |   | 13c. CITY OR TOWN<br><b>Lanham</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>9133 6th Street</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>GEORGE ROUNTREE</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>UNKNOWN</b>  |   |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>UNKNOWN</b>  |   | 17. INFORMANT Address<br><b>GEORGE A. ROUNTREE, SAME AS #13</b>                   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho-pneumonia - bilateral.</b><br><b>582X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Chronic Nephritis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |   |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>592X</b>   |  |  |   |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>              |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.<br><b>19</b>               |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>Oct. 13, 1968</b> , to <b>Oct. 22, 1968</b> , that (X) (we) last saw the deceased alive on <b>Oct. 22, 1968</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did not) view the body after death.   |  |  |   |   |   |   |  |  |  |  |
| 22b. SIGNATURE <b>Roger B. Ingham</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |   |   |   | 22c. DATE SIGNED<br><b>Oct. 22, 1968</b>  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Roger B. Ingham, M. D.</b>   |  |  |   |   |   | 22e. ADDRESS<br><b>Prince Geo. Gen'l Hospital, Cheverly, Md.</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>10-25-1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FORT LINCOLN</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>COLMAR MANOR, MARYLAND</b>                                  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>W.W. CHAMBERS Co. RIVERDALE, Md.</b>   |  |  |   | 25a. REC'D BY REGISTRAR<br><b>OCT 28 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |  |  |  |

*Journal of Management Education*



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14946

14956

|  |                  |  |  |   |   |  |   |  |  |  |
|--|------------------|--|--|---|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)<br>First Middle Last<br>Ann Mae Ruth   |                  |  | 2a. DATE KNOWN OF DEATH<br>MATED <input checked="" type="checkbox"/> 10-22-68 19 8:05pm                |   |   | 2b. HOUR   |   |  |  |  |
| 3. SEX<br>Female   | 4. RACE<br>White | 5. DATE OF BIRTH<br>Mrach 22-91  | 6. AGE (in years last birthday)<br>77 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS<br>HOURS MIN.   | 2c. DATE PRONOUNCED DEAD<br>Month 10 Day 22 Year 68 8:25pm M   |   |  | 2d. HOUR                                     |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Wash., DC   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Prince George's Md.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Cheverly  |                  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Prince George Hospital |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |                  |  | 13b. COUNTY<br>Prince George's   |   |   | 13c. CITY OR TOWN<br>Marlowe Hgts.   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>2900 St. Clair Drive |
| 14. FATHER'S NAME<br>First Middle Last<br>John McDonald  |                  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Annie Groves  |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No  |                  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)                                      |   |   | 17. INFORMANT ADDRESS<br>Anna M. Beaton (Dau.) Same as # 13  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Heart failure<br>4129<br>DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease<br>minutes<br>over 1 yr<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                  |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>4200 Diabetes - known over 5 yrs.   |                  |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County                                       | State  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                  |  |  |   |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>John Kehoe MD  |                  |  | M.D.<br>Riverdale, Md.   |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town, or county) |   | 22b. DATE SIGNED<br>10-23-68   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                  |  | 23b. DATE<br>Oct. 25, 68   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery                       |  |   | 23d. LOCATION (City or Town) (County) (State)<br>Suitland, Maryland                  |  |  |
| 24. FUNERAL DIRECTOR<br>Simmons Bros.  |                  |  | ADDRESS<br>Wash.,  |   |   | 25a. REC'D BY REGISTRAR<br>DATE<br>OCT 25 1968   |   | 25b. REGISTRAR'S SIGNATURE<br>J Charles Judge  |  |  |
| 26. ADDRESS<br>Simmons Bros. 1661-Gd. Hope Road SE DC  |                  |  |  |   |   |  |   |  |  |  |

1-25-68

1-25-68

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

AGE: [illegible]

SEX: [illegible]

RACE: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

CAUSE OF DEATH: [illegible]

MANNER OF DEATH: [illegible]

DATE OF EXAMINATION: [illegible]

SIGNATURE OF EXAMINER: [illegible]

DATE OF SIGNATURE: [illegible]

PLACE OF SIGNATURE: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

AGE: [illegible]

SEX: [illegible]

RACE: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

CAUSE OF DEATH: [illegible]

MANNER OF DEATH: [illegible]

DATE OF EXAMINATION: [illegible]

SIGNATURE OF EXAMINER: [illegible]

DATE OF SIGNATURE: [illegible]

PLACE OF SIGNATURE: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

AGE: [illegible]

SEX: [illegible]

RACE: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

CAUSE OF DEATH: [illegible]

MANNER OF DEATH: [illegible]

DATE OF EXAMINATION: [illegible]

SIGNATURE OF EXAMINER: [illegible]

DATE OF SIGNATURE: [illegible]

PLACE OF SIGNATURE: [illegible]

DATE OF DEATH: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <span>14847</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>14957</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br/> <b>CERTIFICATE OF DEATH</b> </div>  |  |  |  |  |  |  |   |   |   |  |   |
|---|--|--|--|--|--|--|---|---|---|--|---|
| 1. DECEASED-NAME (Type or print) <b>Baby Girl Savoy</b>   |  |  |  |  |  | 2a. DATE OF DEATH <b>Oct. 9, 1968</b>  |   |   | 2b. HOUR <b>7:30PM</b>                  |  |   |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>Negro</b>   |  | 5. DATE OF BIRTH <b>Oct. 5, 1968</b>   |  |  | 6. AGE (In years lost birthday) <b>5</b> YRS. |   | IF UNDER 1 YEAR<br>MONTHS <b>5</b> DAYS |  | IF UNDER 24 HRS.<br>HOURS <b>5</b> MIN. |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Prince George's</b> Md.  |   |   |   |  |   |
| 10. CITY OR TOWN OF DEATH <b>Cheverly</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George's Gen'l Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   |   | 12b. KIND OF BUSINESS OR INDUSTRY       |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Prince George's</b>   |  | 13c. CITY OR TOWN <b>Coral Hills</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET AND NUMBER <b>1413 Boone Hill Rd.</b>                               |   |  |   |
| 14. FATHER'S NAME First <b>First</b> Middle <b>Middle</b> Last <b>Last</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>First</b> Middle <b>Middle</b> Last <b>Last</b>  |  |  |   |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |   |   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hyalin membrane of lungs with bronchopneumonia</b><br><b>7669</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Breech Presentation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>7730</b>  |  |  |  |  |  |  |   |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b> |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |   |   |   |  |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |   |   |   |  |   |
| 22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>Oct. 5, 1968</b> , to <b>Oct. 9, 1968</b> , that <del>he</del> (we) lost <del>the</del> the deceased alive on <b>Oct. 9, 1968</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>not</del> view the body after death.                |  |  |  |  |  |  |   |   |   |  |   |
| 22b. SIGNATURE <b>Horacio</b>   |  |  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED <b>Oct. 11, 1968</b>   |   |  |   |
| 22d. PHYSICIAN'S NAME (Type) <b>Bernardo Alvarado, M. D.</b>  |  |  |  |  |  | 22e. ADDRESS <b>Prince George's Gen'l Hospital, Cheverly.</b>  |   |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE <b>10/26/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. General Hosp.</b>  |  | 23d. LOCATION (City or Town) (County) <b>Cheverly, Maryland</b>  |   |   |   |  |   |
| 24. FUNERAL DIRECTOR <b>William A. Parker, Assoc. Administrator</b>   |  |  |  |  |  | 25a. REC'D BY REGISTRAR DATE <b>OCT 29 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>                              |   |  |   |

3321

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |                                   |  |
|--|--|--|--|--|--|--|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |                                   |  |
| 14948  |  |  |  |  | 14958  |  |  |                                   |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  |  | 2a. DATE OF DEATH  |  |  | 2b. HOUR                          |  |
| First Middle Last  |  |  |  |  | Month Day Year   |  |  | P. M.                             |  |
| Myrtle Schools   |  |  |  |  | October 31 1968  |  |  | 5:10 P. M.                        |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR                   |  |
| Female   |  | Negro  |  | 7/4/1897   |  | 71 YRS.  |  | MONTHS DAYS HOURS MIN.            |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                                   |  |
| Virginia   |  | U.S.A.   |  |  |  | Prince Georges Md.   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Glenn Dale   |  |  | Glenn Dale Hospital  |  |  | Unknown - Retired  |  | --                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER            |  |
| D.C.   |  |  |  | Washington   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  | 1619 1st Street, N.W.             |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |                                   |  |
| First Middle Last  |  |  | First Middle Last  |  |  |  |  |                                   |  |
| Jacob Crawford   |  |  | Carrie Tucker  |  |  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |  |  |                                   |  |
| No   |  |  | --   |  | Decedent   |  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 Recurrent cerebrovascular accident with quadriplegia   |  |  |  |  |  |  |  |                                   | 3 mo.  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 337X   |  |  |  |  |  |  |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis  |  |  |  |  |  |  |  |                                   | years  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic & hypertensive cardiovascular disease; pulmonary tuberculosis, moderately advanced; right mastectomy 1964 for carcinoma of the breast                  |  |  |  |  |  |  |  |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |  |
|  |  |  |  |  |  |  |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |                                   |  |
|  |  |  |  |  |  |  |  |                                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |                                   |  |
|  |  |  |  |  |  |  |  |                                   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 10/18/1968, to 10/31/1968, that (X) (we) last saw the deceased alive on 10/31/1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death. |  |  |  |  |  |  |  |                                   |  |
| 22b. SIGNATURE Moe Weiss   |  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED 10/31/1968  |                                   |  |
| 22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.   |  |  |  |  | 22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland  |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |                                   |  |
| Burial   |  | 11-6-1968  |  | Arlington National   |  | Arlington, Virginia  |  |                                   |  |
| 24. FUNERAL DIRECTOR ADDRESS Malsaw Schey Inc 424 R St NW Washington DC  |  |  |  |  | 25a. REC'D BY REGISTRAR DATE NOV 6 1968  |  | 25b. REGISTRAR'S SIGNATURE f Charles Judge                           |                                   |  |

1992



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <span>14949</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>14959</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br/> <b>CERTIFICATE OF DEATH</b> </div>  |  |  |  |  |  |   |  |  |  |  |  |   |  |       |                                |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|---|--|-------|--------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><b>Robert</b>   |  |  | Middle<br><b>W.</b>   |  |  | Last<br><b>Seeley Sr.</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>1</b> , Day <b>1968</b> Year                      |  |       | 2b. HOUR<br><b>7:15 PM</b>     |  |  |
| 3. SEX<br><b>Male</b>   |  |  | 4. RACE<br><b>Caucasian</b>  |  |  | 5. DATE OF BIRTH<br><b>March 4, 1982</b>  |  |  | 6. AGE (In years last birthday)<br><b>86</b> YRS.                                    |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |       | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Norfolk, Va</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.                                     |  |  |   |  |       |                                |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince Geo.Gen'l Hospital</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Retired-Marlow Coal Co.</b>                                    |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |  |       |                                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Prince George's</b>  |  |  | 13c. CITY OR TOWN<br><b>Hyattsville</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>5102 Annapolis Road</b>                            |  |       |                                |  |  |
| 14. FATHER'S NAME First<br><b>Rodney W.</b>   |  |  | Middle<br><b>Seeley</b>  |  |  | Last  |  |  | 15. MOTHER'S MAIDEN NAME First<br><b>Unknown</b>                                     |  |  | Middle  |  |       | Last                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.<br><b>672 07 5501</b>   |  |  | 17. INFORMANT<br><b>Necie A. Seeley</b>   |  |  | Address<br><b>5102-Annapolis Rd</b>  |  |  |   |  |       |                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>massive Pulmonary embolization</b><br><b>5620</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>5721</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Diverterculitis with ruptured into</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>abdominal cavity</b><br>(c) <b>causing peritonitis</b> |  |  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs.</b><br><b>6 days?</b> |  |       |                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>generalized atherosclerosis with atherosclerotic heart disease</b>   |  |  |  |  |  |   |  |  |  |  |  |   |  |       |                                |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |  |   |  |       |                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |   |  |       |                                |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                     |  |  | 21f. LOCATION Street or R.F.D. No.  |  |  | City or Town   |  |  | County  |  | State |                                |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Sept. 23, 1968</b> , to <b>Oct. 1, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Oct. 1, 1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.    |  |  |  |  |  |   |  |  |  |  |  |   |  |       |                                |  |  |
| 22b. SIGNATURE<br><b>Faruk Ozer</b>   |  |  | DEGREE   |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><b>10.2.68</b>   |  |  |   |  |       |                                |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Faruk Ozer, M. D.</b>  |  |  | 22e. ADDRESS<br><b>Prince Geo.Gen'l Hospital, Cheverly, Md.</b>  |  |  |   |  |  |  |  |  |   |  |       |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE<br><b>Oct. 4-68</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westfield Bap. Cem.</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Westfield, North Carolina</b>    |  |  |   |  |       |                                |  |  |
| 24. FUNERAL DIRECTOR<br><b>Simmons Bros</b>   |  |  | ADDRESS<br><b>Wash DC</b>  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 3 1968</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>                                 |  |  |   |  |       |                                |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>VR A15 (4)<br/>30M REV. 1/68</span> <span>1661-Good Hope Rd SE</span> </div>   |  |  |  |  |  |   |  |  |  |  |  |   |  |       |                                |  |  |

2022

FIGURE 2.11E-2007

*Erhard C. Honig*

1992

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |   |  |                                   |  |  |
|--|--|--|--|--|---|---|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |   |  |                                   |  |  |
| 14950  |  |  |  |  | 14960   |   |  |                                   |  |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  |  | 2a. DATE OF DEATH   |   |  | 2b. HOUR                          |  |  |
| INFANT MALE SKINNER  |  |  |  |  | OCTOBER 11 1968   |   |  | 1605 M                            |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR                   |  |  |
| Male   |  | Caucasian  |  | 10 October 1968  |   | YRS.  |  | MONTHS DAYS                       |  |  |
| 7a. BIRTHPLACE (State or foreign)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |                                   |  |  |
| MARYLAND   |  | USA  |  |  |   | PRINCE GEORGES Md.  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| ANDREWS AFB  |  |  | Malcolm Grow USAF Hospital   |  |   |   |  |                                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |  |
| Md.  |  |  | Prince Georges   |  | Oxon Hill   |   | YES  |                                   | 9502 Clarion Road                            |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |   |  |                                   |  |  |
| First Middle Last  |  |  | First Middle Last  |  |   |   |  |                                   |  |  |
| Paul E Skinner   |  |  | Joan V Anderson  |  |   |   |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address   |   |  |                                   |  |  |
|  |  |  |  |  | Father 9502 Clarion Dr. Oxon Hill, Md   |   |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |   |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory distress syndrome</u>  |  |  |  |  |   |   |  |                                   | 18 hrs                                       |  |
| 7762 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Prematurity</u>   |  |  |  |  |   |   |  |                                   | 18 hrs                                       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)   |  |  |  |  |   |   |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |   |   |  |                                   |  |  |
| 7735   |  |  |  |  |   |   |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |  |  |
|  |  |  |  |  |   |   |  |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |                                   |  |  |
|  |  |  |  |  |   |   |  |                                   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |   | City or Town  |  | County State                      |  |  |
|  |  |  |  |  |   |   |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1100</u> , 19 <u>68</u> , to <u>1100</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1100</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |   |  |                                   |  |  |
| 22b. SIGNATURE <u>Raymond L Hintz MD</u>   |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |   | 22c. DATE SIGNED <u>1100 68</u>   |  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>Raymond L Hintz</u>  |  |  |  | 22e. ADDRESS <u>Malcolm Grow USAF Hospital Andrews AFB, Washington, D.C. 20331</u>   |   |   |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |  |  |
| <u>Burial</u>  |  | <u>Oct. 24, 1968</u>   |  | <u>Arlington National</u>  |   | <u>Arlington, Virginia</u>  |  |                                   |  |  |
| 24. FUNERAL DIRECTOR <u>C. M. James</u> <u>Murphy Funeral Home</u> <u>Arlington, Virginia 22204</u>  |  |  |  | 25a. REC'D BY REGISTRAR <u>OCT 24 1968</u>   |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  |                                   |  |  |

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CONTRACTING OUT OF THE PUBLIC SECTOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| 14952   |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  | 14961  |  |                                |  |  |  |
|---|--|--|--|---|--|--|--|--|--|--------------------------------|--|--|--|
| 1. DECEASED NAME<br>(Type or print)   |  |  |  | First Middle Last   |  |  |  | 2a. DATE OF DEATH<br>Month Day Year                                  |  |                                |  | 2b. HOUR                                     |  |
| JOAN VANCE SKINNER  |  |  |  |   |  |  |  | 21 October 1968  |  |                                |  | 4:35P M                                      |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |  |  | 6. AGE (In years last birthday)                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| Female  |  | Caucasian  |  | June 30, 1936   |  |  |  | 32 YRS.  |  |                                |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |                                |  |  |  |
| Wyoming   |  | USA  |  |   |  | Prince George's County Md.   |  |  |  |                                |  |  |  |
| 1D. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |                                |  |  |  |
| Andrews AFB   |  | Malcolm Grow USAF Hospital   |  | Housewife   |  |  |  |  |  |                                |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |                                |  |  |  |
| Md  |  | P G County   |  | Oxon Hill   |  |  |  | 9502 Clarion Road  |  |                                |  |  |  |
| 14. FATHER'S NAME First Middle Last   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last  |  |  |  |  |  |                                |  |  |  |
| Gerald Anderson   |  |  |  | Nancy Vance   |  |  |  |  |  |                                |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address  |  |  |  |                                |  |  |  |
| Yes Jun 60 - Jan 62   |  |  |  | 520-34-0150   |  | Paul E Skinner, 9502 Clarion Rd, Oxon Hill   |  |  |  |                                |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |  |  |  |  |                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 5670 H7 POXEMIA & SHOCK   |  |  |  |   |  |  |  |  |  |                                |  | 1 DAY  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) SEPTIC PULMONARY EMBOLI   |  |  |  |   |  |  |  |  |  |                                |  | 1 DAY  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) SUBDIAPHRAGMATIC ABSCESS  |  |  |  |   |  |  |  |  |  |                                |  | 2 WEEKS                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>576x  |  |  |  |   |  |  |  |  |  |                                |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                |  |  |  |
| 17 OCT 68   |  | DRAINAGE OF ABSCESS.   |  |   |  |  |  |  |  |                                |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |                                |  |  |  |
|   |  |  |  |   |  |  |  |  |  |                                |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |                                |  |  |  |
|   |  |  |  |   |  |  |  |  |  |                                |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 21 OCT, 19 68, that (I) (we) last saw the deceased alive on 21 OCT 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |                                |  |  |  |
| 22b. SIGNATURE<br>Leonard R Farber MD DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |  |  |                                |  | 22c. DATE SIGNED<br>21 OCT 68                |  |
| 22d. PHYSICIAN'S<br>LEONARD R FARBER CAPT USAF MC   |  |  |  |   |  |  |  |  |  |                                |  | 22e. ADDRESS<br>Malcolm Grow USAF Hospital   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |                                |  |  |  |
| Burial  |  | Oct. 24, 1968  |  | Arlington National  |  | Arlington, Virginia  |  |  |  |                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>C. M. Francis Murphy Funeral Home<br>Arlington, Virginia  |  |  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE OCT 24 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                          |  |                                |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|   |  |  |                            |   |                                   |  |  |
|---|--|--|----------------------------|---|-----------------------------------|--|--|
| 14952   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                            |   |                                   | 14962  |  |
| CERTIFICATE OF DEATH  |  |  |                            |   |                                   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First                      | Middle  | Last                              | 2a. DATE OF DEATH<br>Month Day Year  |  |
| GEORGE WILSON SMITH   |  |  |                            |   |                                   | OCTOBER 31, 1968   |  |
| 3. SEX  |  | 4. RACE  |                            | 5. DATE OF BIRTH  |                                   | 6. AGE (In years lost birthday)  |  |
| MALE  |  | WHITE  |                            | 8-31-1906   |                                   | 62 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. COUNTY OF DEATH   |  |
| North Carolina  |  | U S A  |                            |   |                                   | Prince Georges Md.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                            | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Hillcrest Heights   |  | 2421 Colebrook Dr.   |                            | ret. U S Gov.   |                                   | U S Gov.   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |                            | 13c. CITY OR TOWN   |                                   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| MARYLAND  |  | PRINCE GEORGES   |                            | HILLCREST HGTS.   |                                   | 2421 COLEBROOK DRIVE   |  |
| 14. FATHER'S NAME   |  |  | First                      | Middle  | Last                              | 15. MOTHER'S MAIDEN NAME   |  |
| George W. Smith   |  |  |                            |   |                                   | Annie Freeland   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address             |  |  |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (if yes give war or dates of service)   |  |  | 7-15-42 - 1945 579-22-3553 |   | Agnes G. Smith 2421 Colebrook Dr. |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br><u>4109</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>12y</u><br><u>10yrs</u> |  |  |                            |   |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><u>4201</u>   |  |  |                            |   |                                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                            | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                            | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-1</u> , 19 <u>58</u> , to <u>10-31</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-2</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  | 22b. SIGNATURE<br><u>John J. Hagedorn M.D.</u>                               |                            | 22c. DATE SIGNED<br><u>10/31/68</u>   |                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS<br><u>2964 Nichols Ave SE</u>                                   |                            |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |                            | 23c. NAME OF CEMETERY OR CREMATORY  |                                   | 23d. LOCATION (City or Town) (County) (State)  |  |
| Burial  |  | 11-4-68  |                            | Resurrection Cemetery   |                                   | Clinton Pr. Geo. Md.   |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |                            | 25a. REC'D BY REGISTRAR   |                                   | 25b. REGISTRAR'S SIGNATURE   |  |
| Robert E. Wilhelm Fun. Home   |  | 4508 Suitland Rd.<br>Suitland, Md.   |                            | DATE NOV 6 1968   |                                   | <u>J. Charles Judge</u>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

| 14953   |  |   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  | 14963   |  |  |  |                                |  |
|---|--|---|--|---|--|--|--|---|--|--|--|--------------------------------|--|
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  |  |  |                                |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Sophia J. Smith   |  |   |  | 2a. DATE OF DEATH Month Day Year<br>10 18 68  |  |  |  | 2b. HOUR<br>M   |  |  |  |                                |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>5/26/75   |  |  |  | 6. AGE (In years last birthday)<br>93 YRS.                            |  | IF UNDER 1 YEAR<br>MONTHS DAYS                     |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Prince George Md.  |  |   |  |  |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Clinton, Md.   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Fine View Gardens |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                  |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  | 13b. COUNTY<br>Pr. Geo.   |  | 13c. CITY OR TOWN<br>Bladensburg  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  | 13e. STREET AND NUMBER<br>4110 Edmonston Avenue                       |  |  |  |                                |  |
| 14. FATHER'S NAME First Middle Last<br>Cornelius Trestlee   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Julia Kensler   |  |  |  |   |  |  |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>unknown  |  | (If yes give war or dates of service)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>214-14-3686   |  | 17. INFORMANT Address<br>Margaret Tolson, Clinton, Maryland 20735                                    |  |   |  |  |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br><u>4272</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>CVA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>4330</u> |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |  |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |  |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/12</u> , 19 <u>68</u> , to <u>10/18</u> , 19 <u>68</u> , that (I) (we) lost the deceased on <u>10/18</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |  |  |  |                                |  |
| 22b. SIGNATURE<br><u>Charles R. Lapin, M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |   |  |   |  |  |  |   |  | 22c. DATE SIGNED                                   |  |                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>CHARLES R. LAPIN, MD</u>   |  |   |  |   |  |  |  |   |  | 22e. ADDRESS<br><u>CLINTON, MD</u>                 |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>Oct 22, 1968   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Suitland Pro Geo Md. |  |  |  |                                |  |
| 24. FUNERAL DIRECTOR<br>F. Gasch's Sons   |  |   |  | ADDRESS<br>Hyattsville, Md.   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br>OCT 22 1968                        |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |  |                                |  |

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14964

CERTIFICATE OF DEATH

|   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |   |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(Type or print)<br><b>Baby</b>  |  |  | First<br><b>Girl</b>   |  |  | Middle<br><b>Spriggs</b>   |  |  | Last   |  |  | 2a. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>24</b> Year <b>1968</b> |  |  | 2b. HOUR<br><b>8:15AM</b>                       |  |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>Caucasian</b>  |  |  | 5. DATE OF BIRTH<br><b>Oct. 24, 1968</b>   |  |  | 6. AGE (In years last birthday)<br>YRS. <b>3</b> MONTHS <b>4</b> DAYS <b>5</b>       |  |  | IF UNDER 1 YEAR<br>MONTHS <b>3</b> DAYS <b>4</b>                      |  |  | IF UNDER 24 HRS.<br>HOURS <b>3</b> MIN <b>4</b> |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Prince George's</b>   |  |  | Md.   |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince Geo.Gen'l Hospital</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |  |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Prince George's</b>  |  |  | 13c. CITY OR TOWN<br><b>Seat Pleasant</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>6517 C Street</b>                        |  |  |   |  |  |
| 14. FATHER'S NAME<br>First <b>Ernest</b> Middle <b>Leroy</b> Last <b>Spriggs</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Dorothy</b> Middle <b>Yvonne</b> Last <b>DeVore</b>                         |  |  |  |  |  |  |  |  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT  |  |  | Address  |  |  |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Immaturity</b><br><b>777X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |  |  |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)<br><b>776X</b>  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b>   |  |  |   |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                     |  |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State  |  |  |  |  |  |   |  |  |   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Oct. 24, 1968</b> , to <b>Oct. 24, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Oct. 24, 1968</b> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did <del>not</del> ) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Bernardo Alvarado, M. D.</b>   |  |  | 22c. DATE SIGNED<br><b>Oct. 24, 1968</b>   |  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>Prince Geo.Gen'l Hospital, Cheverly, Md.</b>  |  |  |  |  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE<br><b>11-2-68</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Prince George's General</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cheverly, Maryland</b>           |  |  |   |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Harry W. Penn, Jr., Administrator</b>  |  |  | 25a. REC'D BY REGISTRAR<br><b>NOV 6 1968</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |  |  |  |   |  |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14955

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

JUANITA

CERTIFICATE OF DEATH

14965

|  |  |  |   |   |  |   |  |
|--|--|--|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>JUANITA MOORE STANSELL</b>  |  |  | 2a. DATE OF DEATH<br>October <sup>Month</sup> 27, <sup>Day</sup> 1968 <sup>Year</sup> |   |  | 2b. HOUR<br>7:10 <sup>P</sup>   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasion   |   | 5. DATE OF BIRTH<br>September 25, 1908  |  | 6. AGE (In years last birthday)<br>60 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Prince George Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Camp Springs  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Malcolm Grow USAF Hosp |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Registered Nurse   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Prince Geo  |   | 13c. CITY OR TOWN<br>Camp Springs   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>4409 Simmons Lane  |  |  |   |   |  |   |  |
| 14. FATHER'S NAME First Middle Last<br>James Malcolm Wilfong   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Fanny Wiseman                           |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) No   |  | 16b. SOCIAL SECURITY NO.<br>579-58-1104  |   | 17. INFORMANT<br>4409 Simmons Lane<br>Barbara Dodge Camp Springs, Md.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4201   |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>October 24, 1968</u> , to <u>October 27, 1968</u> , that (X) (we) last saw the deceased alive on <u>October 24</u> 1968, and that in (our) (my) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.                  |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><u>Michael S. Goldstein</u> DEGREE   |  |  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br>October 27, 1968  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>MICHAEL S. GOLDSTEIN   |  |  |   | 22e. ADDRESS<br>Malcolm Grow USAF Hospital<br>Andrews AFB, Washington, D.C. 20331   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>10-31-68  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington Natl.   |  | 23d. LOCATION (City or Town) (County) (State)<br>Arlington, Va                                  |  |
| 24. FUNERAL DIRECTOR<br>Simmons Bros.  |  |  |   | ADDRESS<br>Wash D.C.  |  | 25a. REC'D BY REGISTRAR<br>OCT 30 1968  |  |
|  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |   |  |

14865

14865

OCT 30 1960

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |   |  |   |                                 |  |   |  |  |
|---|---------|---|--|---|---------------------------------|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |   |  |   |                                 |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or Print)   |         |   | First Middle Last                                    |   |                                 | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED  |   | 2b. HOUR   |  |
| George Stewart  |         |   |  |   |                                 | 10-10-68 12:55am M   |   |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (In years<br>lost birthday)                   | IF UNDER 1 YEAR<br>MONTHS DAYS  |                                 | IF UNDER 24 HRS.<br>HOURS MIN.   |   | 2c. DATE PRONOUNCED DEAD   |  |
| Male  | White   | 1-16-1906   | 62 YRS.  |   |                                 |  |   | 10 10 68 19 3:15am M   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9. COUNTY OF DEATH   |   |  |  |
| Washington DC   |         | USA   |  |   |                                 | Prince George's  |   | Md.  |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |                                 | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |   |  |  |
| Cheverly  |         | Prince George Hospital  |  | Retd U. S. Govt.  |                                 |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |         | 13b. COUNTY   |  | 13c. CITY OR TOWN   |                                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER   |  |
| Maryland  |         | Prince George's Boulevard Hgts.   |  |   |                                 |  |   | 4916 Byers Street, S.E.  |  |
| 14. FATHER'S NAME<br>First Middle Last  |         |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last        |   |                                 |  |   |  |  |
| Albert E. Stewart   |         |   | Catherine Nicholson                                  |   |                                 |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         |   | 16b. SOCIAL SECURITY NO.                             |   | 17. INFORMANT<br>ADDRESS        |  |   |  |  |
| Yes WWII  |         |   |  |   | Eva E. Stewart 4916-Byers St SE |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pulmonary hemorrhage<br>DUE TO, OR AS A CONSEQUENCE OF Pulmonary tuberculosis<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.  |         |   |  |   |                                 |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>hours<br>over 6 mo. |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |   |  |   |                                 |  |   |  |  |
| 19a. DATE OF OPERATION  |         |   | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED? |   |                                 |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.                          |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                 |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No.  |                                 | City or Town   |   | County State   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |   |  |   |                                 |  |   |  |  |
| ACTUAL<br>SIGNATURE   |         |   | M.D.   |   |                                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                      |   | 22b. DATE SIGNED   |  |
| EXAMINER'S<br>NAME (Type)   |         |   |  |   |                                 | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                  |   | 10-11-68   |  |
| John Kehoe MD   |         |   | Riverdale, Md.                                       |   |                                 | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                          |   | ADDRESS (Street, city, town, or county)                                |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                 | 23d. LOCATION (City or Town)   |   | (County) (State)   |  |
| Burial  |         | Oct 12-68   |  | Cedar Hill Cemetery   |                                 | Suitland, Maryland   |   |  |  |
| 24. FUNERAL DIRECTOR<br>Simmons Bros.   |         |   |  | ADDRESS Wash DC   |                                 | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |  |
| 1661-Good Hope Rd SE  |         |   |  |   |                                 | OCT 14 1968  |   | Charles Judge  |  |

14038

14038

OR  
UNIT



|                     |  |                |  |                  |  |                  |  |
|---------------------|--|----------------|--|------------------|--|------------------|--|
| Name                |  | Last           |  | First            |  | Middle           |  |
| John                |  | D              |  | W                |  | H                |  |
| Address             |  | City           |  | State            |  | Zip              |  |
| 1234 Main St        |  | Springfield    |  | Ill              |  | 62761            |  |
| Occupation          |  | Education      |  | Age              |  | Sex              |  |
| Teacher             |  | High School    |  | 35               |  | Male             |  |
| Religion            |  | Marital Status |  | Date of Birth    |  | Place of Birth   |  |
| Catholic            |  | Married        |  | 10-15-1900       |  | Springfield, Ill |  |
| Social Security No. |  | Maiden Name    |  | Date of Marriage |  | Date of Divorce  |  |
| 123-45-6789         |  | John D. W. H.  |  | 01-15-1925       |  |                  |  |
| Signature           |  | Date           |  | Time             |  | Place            |  |
| [Signature]         |  | 10-15-1960     |  | 10:00 AM         |  | Springfield, Ill |  |
| Witness             |  | Date           |  | Time             |  | Place            |  |
| [Signature]         |  | 10-15-1960     |  | 10:00 AM         |  | Springfield, Ill |  |
| Notary Public       |  | Date           |  | Time             |  | Place            |  |
| [Signature]         |  | 10-15-1960     |  | 10:00 AM         |  | Springfield, Ill |  |

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14957

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14967

|  |         |                              |   |   |        |  |  |  |   |                        |      |
|--|---------|------------------------------|---|---|--------|--|--|--|---|------------------------|------|
| 1. DECEASED-NAME<br>(Type or Print)  |         |                              | First   | Middle  | Last   | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> 10-22-68 1910:10pm |  |  |   | 2b. HOUR               |      |
| John   |         |                              | Albert  |   |        | Stewart  |  |  |   |                        |      |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 1896  | 6. AGE (in years<br>last birthday)  | 71 YRS | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD<br>Month 10 22 68 Day Year 1910:48pm                        |   | 2d. HOUR               |      |
| Male   | White   | 12-27-1896                   |   | 71  |        |  |  |  |   |                        |      |
| 7a. BIRTHPLACE (State or foreign<br>country)   |         | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. COUNTY OF DEATH<br>Prince George's Md.  |  |  |   |                        |      |
| Maryland.  |         | USA                          |   |   |        |  |  |  |   |                        |      |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |        | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)       |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY          |                        |      |
| Cheverly   |         |                              | Prince George Hospital  |   |        |  |  |  |   |                        |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |         |                              | 13b. COUNTY   |   |        | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER |      |
| Maryland   |         |                              | Prince George's Hillcrest Hgts.   |   |        |  |  |  |   | 2602 26th. Ave.        |      |
| 14. FATHER'S NAME  |         |                              | First   | Middle  | Last   | 15. MOTHER'S MAIDEN NAME   |  |  | First   | Middle                 | Last |
| Theodore   |         |                              | Stewart   |   |        | Mary   |  |  | Hayden  |                        |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |         |                              | 16b. SOCIAL SECURITY NO.<br>WW 1  |   |        | 17. INFORMANT<br>ADDRESS<br>Joseph A. Stewart-Mechanicsville, Md                                 |  |  |   |                        |      |
| Yes  |         |                              |   |   |        |  |  |  |   |                        |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Heart failure<br>4129<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>minutes<br>unknown |         |                              |   |   |        |  |  |  |   |                        |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>4200  |         |                              |   |   |        |  |  |  |   |                        |      |
| 19a. DATE OF OPERATION   |         |                              | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                            |   |        | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  |  |   |                        |      |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |         |                              | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19                       |   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                  |  |  |   |                        |      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |         |                              | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |   |        | 21f. LOCATION Street or R.F.D. No. City or Town County State                                     |  |  |   |                        |      |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>    |         |                              |   |   |        |  |  |  |   |                        |      |
| ACTUAL<br>SIGNATURE  |         |                              | EXAMINER'S<br>NAME (Type)   |   |        | John Kehoe MD Riverdale, Md.   |  |  | 22b. DATE SIGNED<br>10-23-68                  |                        |      |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |         |                              | 23b. DATE   |   |        | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION (City or Town) (County) (State) |                        |      |
| Burial   |         |                              | Oct. 25, 68   |   |        | Washington National Cem.   |  |  | Suitland, Maryland                            |                        |      |
| 24. FUNERAL DIRECTOR<br>Simmons Bros.  |         |                              | ADDRESS<br>Wash.  |   |        | 25a. REC'D BY REGISTRAR<br>ACT 25 1968   |  |  | 25b. REGISTRAR'S SIGNATURE<br>J Charles Judge |                        |      |
| 1661-Gd. Hope Rd. SE. DC.  |         |                              |   |   |        |  |  |  |   |                        |      |

10

Test 10

4

— *Source: U.S. Census Bureau, 1997.*

952 J. A. Roberts and others



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14958

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14968

|  |                         |  |   |   |                                |   |  |  |   |   |  |
|--|-------------------------|--|---|---|--------------------------------|---|--|--|---|---|--|
| 1. DECEASED-NAME<br>(Type or Print)<br><b>Carolyn</b>  |                         |  | First Middle Last<br><b>Strausbaugh</b>   |   |                                | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br><b>10-28-68</b>  |  |  | 2b. HOUR<br>19 3:50pm   |   |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>2-10-1940</b>         | 6. AGE (in years last birthday)<br><b>28</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>10 28 68</b>   |  |  | 2d. HOUR<br>19 3:50pm M   |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>West Va</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b> |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.  |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince George Hospital</b> |   |                                | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>                                |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |                         |  | 13b. CITY OR TOWN<br><b>Prince George's W. Hyattsville</b>  |   |                                | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 13e. STREET AND NUMBER<br><b>5903 37th. Avenue</b>                                  |   |  |
| 14. FATHER'S NAME<br><b>Ernest Youngblood</b>  |                         |  | 15. MOTHER'S MAIDEN NAME<br><b>Corinne Allemong</b>   |   |                                |   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>no</b>   |                         |  | 16b. SOCIAL SECURITY NO.<br><b>219 36 8011</b>  |   |                                | 17. INFORMANT<br><b>Richard S Strausbaugh</b> ADDRESS<br><b>West Hyattsville, Md</b>  |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive pulmonary embolus, acute</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Phlebo thrombosis lower extremity</b><br>(b) <b>From fracture of right tibia and fibula</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>887X</b> |                         |  |   |   |                                |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>over 2 mo.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>9040</b>  |                         |  |   |   |                                |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |                                |   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                         |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <b>8-28- 19 68</b>                                     |   |                                | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Fell in back yard of home</b>   |  |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |                         |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Back yard of home</b>      |   |                                | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>same as #13</b>  |  |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                  |                         |  |   |   |                                |   |  |  |   |   |  |
| ACTUAL SIGNATURE<br><b>John Kehoe MD</b>   |                         |  | EXAMINER'S NAME (Type)<br><b>John Kehoe MD</b>  |   |                                | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town, or county)<br><b>Riverdale, Md.</b> |  |  | 22b. DATE SIGNED<br><b>10-29-68</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         |  | 23b. DATE<br><b>Oct 31, 1968</b>  |   |                                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Zion Church Cemetery</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>York Spring Garden Pa</b>       |   |  |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons, Hyattsville, Md.</b>   |                         |  | ADDRESS<br><b>Hyattsville, Md.</b>  |   |                                | 25a. REC'D BY REGISTRAR<br>DATE<br><b>NOV 1 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>                                |   |  |

14908

14908

EXAMINER'S CERTIFICATE OF DEATH

STATE OF TEXAS  
COUNTY OF DALLAS

|                         |  |                        |  |                         |  |                        |  |
|-------------------------|--|------------------------|--|-------------------------|--|------------------------|--|
| Name of Deceased        |  | Sex                    |  | Age                     |  | Date of Death          |  |
| John Doe                |  | Male                   |  | 45                      |  | 1998-10-15             |  |
| Residence               |  | Occupation             |  | Cause of Death          |  | Manner of Death        |  |
| 123 Main St, Dallas, TX |  | Software Engineer      |  | Myocardial Infarction   |  | Natural                |  |
| Physician               |  | Medical History        |  | Post Mortem Examination |  | Burial or Disposition  |  |
| Dr. J. Smith            |  | Hypertension, Diabetes |  | None                    |  | Buried in Dallas, TX   |  |
| Signature of Physician  |  | Signature of Examiner  |  | Signature of Coroner    |  | Signature of Registrar |  |
| [Signature]             |  | [Signature]            |  | [Signature]             |  | [Signature]            |  |
| Date                    |  | Time                   |  | Place                   |  | Remarks                |  |
| 1998-10-15              |  | 10:30 AM               |  | Dallas, TX              |  | [Blank]                |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <span>14959</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>14969</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>   |  |  |  |  |   |   |  |   |  |
|--|--|--|--|--|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |   | 2a. DATE OF DEATH   |  |   | 2b. HOUR                                     |
| Albert   |  |  | Sturba   |  |   | Oct. 15, 1968   |  |   | 3:30 PM                                      |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                |  |
| Male   |  | Caucasian  |  | Oct. 5, 1892   |   | 76 YRS.   |  |   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |   |  |
| ITALY  |  | U.S.   |  |  |   | prince George's Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Cheverly   |  |  | Prince Geo. Gen'l Hospital   |  |   | MACHINIST   |  |   | GLASS. CO                                    |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER                       |
| Maryland   |  |  | Prince George's  |  | Bowie   |   | YES  |   | 12307 Firtree Lane                           |
| 14. FATHER'S NAME First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |   |   |  |   |  |
| RANIERO STURBA   |  |  | CONSETTO FILARO  |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |   | Address  |   |  |
| No   |  |  | 234 032446   |  | RANIE J. STURBA   |   | SAME AS # 13   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |   |   |  |   |  |
| IMMEDIATE CAUSE (a) <u>Gastrointestinal Hemorrhage;</u>  |  |  |  |  |   |   |  |   |  |
| 534.0 DUE TO, OR AS A CONSEQUENCE OF <u>Acute multiple gastric ulcers; acute</u>   |  |  |  |  |   |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>duodenal ulcer and hemorrhagic esophagitis.</u>  |  |  |  |  |   |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |   |   |  |   |  |
| 5401   |  |  |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes                     |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |   |  |
| 22a. I certify that (I) <del>the doctor</del> attended the deceased from _____, 19____, to <u>Oct. 15, 1968</u> , that (I) <del>we</del> lost saw the deceased alive on <u>Oct. 15, 1968</u> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> (did) <del>did not</del> view the body after death. |  |  |  |  |   |   |  |   |  |
| 22b. SIGNATURE <u>Barry Rosenberg M.D.</u>   |  |  |  |  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED                              |  |
| 22d. PHYSICIAN'S NAME (Type) <u>BARRY ROSENBERG</u>  |  |  |  |  |   | 22e. ADDRESS <u>6501 Landover Road, Cheverly, Md. 20785</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |  |   |  |
| BURIAL   |  | 10-18-1968   |  | GATE OF HEAVEN CEM   |   | WHEATON, MARYLAND.  |  |   |  |
| 24. FUNERAL DIRECTOR <u>W.W. CHAMBERS Co RIVERDALE, MARYLAND</u>   |  |  |  |  |   | 25a. REC'D BY REGISTRAR DATE <u>OCT 23 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> |  |

4553

STATE OF NEW YORK

Albany, New York, Oct. 12, 1892.

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 10th inst.

in relation to the matter of the application of the

Commissioners of the State of New York for the

purpose of the purchase of the land for the

purpose of the purchase of the land for the

purpose of the purchase of the land for the

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1115 (1-68)  
30M REV 1/68

| 14960   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  | 14970                          |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--------------------------------|--|--|--|--|--------------------------------|--|--|--|--|--|--|--|--|--|
| 1   |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |  | First Middle Last  |  |  |  |  | 2a. DATE OF DEATH   |  |  |  |  | 2b. HOUR   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| Annie   |  |  |  |  | Sullivan   |  |  |  |  | Month Day Year<br>October 11, 1968  |  |  |  |  | 9:10 A.M.  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  |  |  | 4. RACE  |  |  |  |  | 5. DATE OF BIRTH  |  |  |  |  | 6. AGE (In years last birthday)  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS |  |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |  |  |  |  |  |  |
| Female  |  |  |  |  | Negro  |  |  |  |  | 12-1-1889   |  |  |  |  | 78 YRS.  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| Virginia  |  |  |  |  | U.S.A.   |  |  |  |  |   |  |  |  |  | Prince Georges Md.   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| Glenn Dale  |  |  |  |  | Glenn Dale Hospital  |  |  |  |  | Unknown - Retired   |  |  |  |  | ---  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  |  | 13b. COUNTY  |  |  |  |  | 13c. CITY OR TOWN   |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER         |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| D.C.  |  |  |  |  |  |  |  |  |  | Washington  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  |  |  |  | 203 N Street S.W.              |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| First Middle Last   |  |  |  |  | First Middle Last  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| Louis   |  |  |  |  | West   |  |  |  |  | Alice   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT   |  |  |  |  | Address  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| No  |  |  |  |  | 579664380  |  |  |  |  | JESSIE WINGFIELD  |  |  |  |  | Decedent 23906LETHORPE ST. N.W. WASH D.C.  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Acute myocardial infarction (clinical)</u>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  | minutes  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4201</u>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  | arteriosclerotic heart disease years   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| (c) <u>generalized arteriosclerosis</u>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  | years  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| <u>Hypertension.</u>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  | 20a. AUTOPSY?   |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  | HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  |  | 21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  | 21f. LOCATION   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| While <input type="checkbox"/> Nat while <input type="checkbox"/> at work   |  |  |  |  |  |  |  |  |  | Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>5/1/</u> , 19 <u>68</u> , to <u>10/11/</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>10/11/</u> 19 <u>68</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  |  |  |   |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| Moe Weiss, MD   |  |  |  |  |  |  |  |  |  |   |  |  |  |  | 10/11/1968   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  | 22e. ADDRESS   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| Moe Weiss, MD   |  |  |  |  |  |  |  |  |  |   |  |  |  |  | Glenn Dale Hospital<br>Glenn Dale, Maryland  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  | 23b. DATE  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| Burial  |  |  |  |  | 10-16-68   |  |  |  |  | Harmon Mem Ph.  |  |  |  |  | Sandover Md  |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  |   |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  |                                |  |  |  |  | 25b. REGISTRAR'S SIGNATURE     |  |  |  |  |  |  |  |  |  |
| W.W. Chambers Co<br>1400 Chapin St. N.W. Wash. D.C.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  | DATE OCT 16 1968   |  |  |  |  |                                |  |  |  |  | J Charles Judge                |  |  |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION

X

●



Amnion (fetal membrane)

...for the olive tree, best leaves

... ..



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |  |  |                                   |  |
|--|--|--|--|---|--|--|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |  |  |                                   |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |                                   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last                          |   |  | 2a. DATE OF DEATH  |  |                                   | 2b. HOUR                                     |
| Gertrude V. Sullivan   |  |  |  |   |  | Oct. 28, 1968  |  |                                   | 8:05 PM                                      |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |  | 6. AGE (In years lost birthday)                                      |                                   | IF UNDER 1 YEAR<br>MONTHS DAYS               |
| Female   |  | Caucasian  |  | 6/19/93   |  |  | 75 YRS.  |                                   | IF UNDER 24 HRS.<br>HOURS MIN                |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                                   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| NEW YORK   |  | U.S.   |  |   |  | Prince George's  |  |                                   | Md.  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Cheverly   |  | Prince Geo. Gen'l Hospital   |  |   | HOUSEWIFE  |  |  |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER            |  |
| Maryland   |  | Prince George's  |  | Greenbelt,  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  | 6 Woodland Way                    |  |
| 14. FATHER'S NAME First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last |   |  |  |  |                                   |  |
| WILLIAM J. NEILL   |  |  | MARGARET MONAGHAN                          |   |  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.                   |   | 17. INFORMANT  |  | Address  |                                   |  |
| NO   |  |  | 094 32 4850                                |   | MRS HELEN G. PETERSON,   |  | SAME AS # 13   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4109</u> <u>Acute myocardial infarct</u>  |  |  |  |   |  |  |  |                                   | 3 weeks                                      |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary thrombosis</u>   |  |  |  |   |  |  |  |                                   | 3 weeks                                      |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u>   |  |  |  |   |  |  |  |                                   | 5 years                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |                                   |  |
| <u>4201</u>  |  |  |  |   |  |  |  |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |                                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |                                   |  |
| 22a. I certify that (I) <del>(the doctor)</del> attended the deceased from <u>October 5, 1968</u> , to <u>Oct. 28, 1968</u> , that (I) <del>(xxx)</del> last saw the deceased alive on <u>Oct. 28, 1968</u> , and that in (my) <del>(xxx)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(xxx)</del> (did) <del>(xxx)</del> view the body after death. |  |  |  |   |  |  |  |                                   |  |
| 22b. SIGNATURE <u>Hans Wodak</u>   |  |  |  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED <u>10-29-1968</u>                                   |                                   |  |
| 22d. PHYSICIAN'S NAME (Type) <u>Hans Wodak, M. D.</u>  |  |  |  |   | 22e. ADDRESS <u>Professional Bldg, Greenbelt, Md. 20770</u>  |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |                                   |  |
| BURIAL   |  | Nov-2, 1968  |  | St. Raymond Cemetery  |  | BRONX, NEW YORK, N.Y.  |  |                                   |  |
| 24. FUNERAL DIRECTOR <u>W.W. CHAMBERS &amp; RIVERDALE, MARYLAND</u>  |  |  |  |   | 25a. REC'D BY REGISTRAR <u>NOV 4 1968</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>                   |                                   |  |

11003

CHRONICLE OF DEATH

1951

DATE OF DEATH: 10. 20. 1950

CAUSE OF DEATH: ...

PLACE OF DEATH: ...

CHURCH: ...

NAME OF DECEASED: ...

AGE: ...

SEX: ...

RELIGION: ...

EDUCATION: ...

OCCUPATION: ...

RESIDENCE: ...

DATE OF BURIAL: ...

PLACE OF BURIAL: ...

NAME OF BURIAL: ...

AGE: ...

SEX: ...

RELIGION: ...

EDUCATION: ...

14962

CERTIFICATE OF DEATH

14972

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |   |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Edgar</b>   |  |  | First <b>J.</b> Middle <b>Swisher</b> Last  |  |  | 2a. DATE OF DEATH<br>Month <b>10</b> Day <b>16</b> Year <b>68</b>   |  |  | 2b. HOUR<br><b>7:15</b> AM   |  |  |
| 3. SEX<br><b>Male</b>  |  |  | 4. RACE<br><b>White</b>   |  |  | 5. DATE OF BIRTH<br><b>January 18, 1905</b>   |  |  | 6. AGE (In years last birthday)<br><b>63</b> YRS.                                    |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Kentucky</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.                                     |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince George's Gen'l Hospital</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>P. G.</b>   |  |  | 13c. CITY OR TOWN<br><b>Greenbelt</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br><b>38 East Ridge Road</b>  |  |  | 14. FATHER'S NAME<br>First <b>Edgar</b> Middle <b>J.</b> Last <b>Swisher</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Sally</b> Middle <b>Roberts</b> Last   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>No</b> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br><b>578 30 3472</b>  |  |  | 17. INFORMANT<br><b>Margaret K Swisher</b>  |  |  | Address<br><b>Greenbelt, Md.</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b><br><b>450 X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b>                        |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>465 X</b>   |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>      |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. _____ Month _____ Day _____ Year <b>19</b><br>P.M. _____                             |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  |  | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-16</b> , 19 <b>68</b> , to <b>10-16</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-16</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.       |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>William C. Weintraub</b> DEGREE _____ ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |   |  |  |   |  |  | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>William C. Weintraub</b>   |  |  |   |  |  |   |  |  | 22e. ADDRESS<br><b>Professional, Bldg. Greenbelt, Md.</b>                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>Oct 19, 1968</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Suitland Pro Geo Md.</b>         |  |  |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons Hyattsville, Md.</b>  |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 21 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>                                |  |  |

11/1/73

TO: DIRECTOR, FBI

FROM:

SAC, [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

TIME: [illegible]

PLACE: [illegible]

BY: [illegible]

FOR: [illegible]

THRU: [illegible]

INFO: [illegible]

NOTE: [illegible]

REFERENCE: [illegible]

ACTION: [illegible]

COMMENTS: [illegible]

APPROVAL: [illegible]

SIGNATURE: [illegible]

DATE: [illegible]

TIME: [illegible]

PLACE: [illegible]

BY: [illegible]

FOR: [illegible]

THRU: [illegible]

INFO: [illegible]

NOTE: [illegible]

REFERENCE: [illegible]

ACTION: [illegible]

COMMENTS: [illegible]

APPROVAL: [illegible]

SIGNATURE: [illegible]

DATE: [illegible]

TIME: [illegible]

PLACE: [illegible]

BY: [illegible]

FOR: [illegible]

THRU: [illegible]

INFO: [illegible]

NOTE: [illegible]

REFERENCE: [illegible]

ACTION: [illegible]

COMMENTS: [illegible]

APPROVAL: [illegible]

SIGNATURE: [illegible]

DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14962

CERTIFICATE OF DEATH

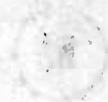
14973

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|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>PRINCE GEORGE</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>—</u> COUNTY <u>✓</u>                               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>FORESTVILLE</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>WASHINGTON, D.C.</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>REGENT REST HOME</u>  |   | d. STREET ADDRESS<br><u>3235 O ST., S.E.</u>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Albert S</u> Middle <u>TAMORRIA</u> Last <u>TAMORRIA</u>   |   | 4. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>23</u> Year <u>1968</u>   |  |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>SEPT. 25, 1919</u>                              |
| 9. AGE (In years last birthday)<br><u>49</u> yrs.  |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>LOCKSMITH</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>WASH. D.C.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>IGNATIUS TAMORRIA</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>FRANCES C. AGATE</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>YES</u> <u>WW II</u>   |   | 16. SOCIAL SECURITY NO.<br><u>579-10-2612</u>  |  |
| 17. INFORMANT<br><u>HOME RECORDS</u>   |   | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia Left Lung</u><br>340X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple Sclerosis</u><br>DUE TO<br>(c) <u>10 Yrs.</u> |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>345X   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                   |
| 21. I certify that (H) (this hospital) attended the deceased from <u>APR. 1</u> , 19 <u>66</u> , to <u>OCT. 23</u> , 19 <u>68</u> , that (H) (we) last saw the deceased alive on <u>OCT. 23</u> , 19 <u>68</u> , and that death occurred at <u>10<sup>15</sup> P.M.</u> , from causes on and on the date stated above.                             |   |  |  |
| 22a. SIGNATURE<br><u>W.B. Sheer</u>  |   | 22b. DATE SIGNED<br><u>OCT. 23, 1968</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>WALTER B. SHEER M.D.</u>  |   | 22d. ADDRESS<br><u>6400 MARLBORO PKE S.E. WASH. D.C. 20028</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 23b. DATE THEREOF<br><u>10/26/1968</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>WASH. NATIONAL</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>SUITLAND, M.D.</u> |
| 24. FUNERAL DIRECTOR<br><u>JAMES T. RYAN, Inc. 317 PA AVE S.E. WASH. D.C.</u>  |   | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   | DATE<br><u>OCT 28 1968</u>   |  |

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STATE OF TEXAS

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THE STATE OF TEXAS, COUNTY OF DALLAS, BEFORE ME, the undersigned authority, on this day personally appeared \_\_\_\_\_, known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

NOTARY PUBLIC



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 14966   |  | CERTIFICATE OF DEATH  |  |   |  |   |  | 14974  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Gemma Emilia Tana  |  |   | 2a. DATE OF DEATH<br>Month 6 Day 1968                          |   |  | 2b. HOUR<br>4:45 PM   |  |  |  |
| 3. SEX<br>female  |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>Nov. 30, 1892   |  | 6. AGE (In years<br>last birthday)<br>75 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Italy   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><del>Italy</del> U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Prince Georges Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Hyattsville  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Hyattsville Nursing Home |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Unknown Housewife   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Own Home  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE Md.  |  | 13b. COUNTY<br>P. G.  |  | 13c. CITY OR TOWN<br>Hyattsville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>2217 Beechwood Rd.                     |  |
| 14. FATHER'S NAME First Middle Last<br>Dominic Barrecho   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Pauline Barrecho |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br>MA 517350   |  | 17. INFORMANT<br>Mr. Francesco J. Tana, Sr.   |  | Address Hyattsville, Md.<br>2217 Beechwood Rd.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4201</u><br>(b) <u>Arteriosclerotic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>immediate</u><br><u>undeterm.</u> |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Cerebrovascular accident</u>   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , 19 <u>  </u> , to <u>Oct 6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct 4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>William F. Simpson MD</u>  |  |   |  | 22c. DATE SIGNED<br><u>10/6/68</u>  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>William F. Simpson MD</u>  |  |   |  | 22e. ADDRESS<br><u>6416 N.H. Ave N.E.</u>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><u>10-9-1968</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Mary's Cemetery</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Washington, D. C.</u>                       |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Clark E. Wisor</u><br><u>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</u>  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>OCT 10, 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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Item 18 Film 406  
11-13-68 and

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14975

|  |                         |   |   |  |                  |   |  |   |
|--|-------------------------|---|---|--|------------------|---|--|---|
| 1. DECEASED-NAME<br>(Type or Print) <b>Craig ALLEN Taylor</b>  |                         |   | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> 10-12-68 19 5:00am |  |                  | 2b. HOUR  |  |   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>9-27-1968</b>  | 6. AGE (In years last birthday)<br><b>14</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <b>14</b> DAYS <b>14</b> HOURS <b>14</b> MIN.  | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD<br>Month <b>10</b> Day <b>12</b> Year <b>68</b> 19 7:45am M  |  |   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Prince George Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>None</b>   |                  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |                         | 13b. COUNTY <b>Prince George's</b>  |   | 13c. CITY OR TOWN <b>Hyattsville</b>   |                  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>6938 Decatur Place</b> |
| 14. FATHER'S NAME First <b>CHARLES W.</b> Middle <b>TAYLOR</b> Last  |                         |   | 15. MOTHER'S MAIDEN NAME First <b>GLADYS</b> Middle <b>HOUSTON</b> Last                                       |  |                  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>   |   | 17. INFORMANT <b>CHARLES W. TAYLOR</b> ADDRESS <b>SAME AS #13</b>  |                  |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5191</b> IMMEDIATE CAUSE (a) <b>Severe pulmonary edema and congestion</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Etiology undetermined</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>SDII</b><br>(b) <b>SDII</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)     |                         |   |   |  |                  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                         |   |   |  |                  |   |  |   |
| 19a. DATE OF OPERATION<br><b>7730</b>  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b> P.M.  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                  |   |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                  |   | 21f. LOCATION Street or R.F.D. No.   |                  | City or Town  |  | County  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |   |   |  |                  |   |  |   |
| ACTUAL SIGNATURE<br><b>John Kehoe MD</b>   |                         |   | M.D.  |  |                  | 22b. DATE SIGNED<br><b>10-13-68</b>   |  |   |
| EXAMINER'S NAME (Type) <b>John Kehoe MD</b>  |                         |   | RIVERDALE, Md.  |  |                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>CREMATION</b>  |                         | 23b. DATE<br><b>10-15-1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FORT LINCOLN CEM</b>  |                  | 23d. LOCATION (City or Town) (County) (State)<br><b>COLMAR MANOR, MARYLAND</b>  |  |   |
| 24. FUNERAL DIRECTOR<br><b>W.W. CHAMBERS Co. RIVERDALE, MD</b>   |                         |   |   | 25a. REC'D BY REGISTRAR<br><b>OCT 16 1968</b>  |                  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |

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# FOR STATE HEALTH DEPT.

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## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |         |  |                                 |   |                                |   |       |   |      |  |
|--|---------|--|---------------------------------|---|--------------------------------|---|-------|---|------|--|
| 1. DECEASED NAME<br>(Type or Print)  |         | First  | Middle                          | Last  | 2a. DATE KNOWN OF DEATH        |   | Month | Day                                     | Year | 2b. HOUR   |
| Howard James Thomas  |         |  |                                 |   | 10-11-68                       |   | 10    | 11                                      | 68   | 19:25pm  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (in years last birthday) | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD  |       | Month                                   | Day  | Year   |
| Male   | White   | 4-20-1919  | 49 YRS                          |   |                                | 10-11-68  |       | 10                                      | 11   | 68   |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. COUNTY OF DEATH  |       | Md.                                     |      |  |
| Cheverly   |         | U S A  |                                 |   |                                | Prince George's   |       |   |      |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                | 12b. KIND OF BUSINESS OR INDUSTRY   |       |   |      |  |
| Cheverly   |         | Prince George Hospital   |                                 | Painter   |                                | self employed   |       |   |      |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE  |         | 13b. COUNTY  |                                 | 13c. CITY OR TOWN   |                                | 13d. INSIDE CITY LIMITS?  |       | 13e. STREET AND NUMBER                  |      |  |
| Maryland   |         | Prince George's  |                                 | Landover  |                                | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 |       | 6726 Eldridge Street                    |      |  |
| 14. FATHER'S NAME  |         | First  | Middle                          | Last  | 15. MOTHER'S MAIDEN NAME       |   | First | Middle                                  | Last |  |
| Lester Thomas  |         |  |                                 |   | Henrietta                      |   |       |   |      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         | 16b. SOCIAL SECURITY NO.   |                                 | 17. INFORMANT   |                                | ADDRESS   |       |   |      |  |
| yes  |         | 457 05 0528  |                                 | Janet A Thomas  |                                | Landover, Md.   |       |   |      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |         |  |                                 |   |                                |   |       |   |      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>minutes<br>over 2 yrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |         |  |                                 |   |                                |   |       |   |      |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |                                 |   |                                | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |       |   |      |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.                       |                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                |   |       |   |      |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                                 | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                |   |       |   |      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |  |                                 |   |                                |   |       |   |      |  |
| ACTUAL SIGNATURE   |         |  |                                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                |   |       | 22b. DATE SIGNED                        |      |  |
| EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.  |         |  |                                 | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                |   |       | 10-11-68                                |      |  |
|  |         |  |                                 | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                |   |       | ADDRESS (Street, city, town, or county) |      |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |                                 | 23c. NAME OF CEMETERY OR CREMATORY  |                                | 23d. LOCATION (City or Town) (County) (State)                                       |       |   |      |  |
| Burial   |         | 10/14/68   |                                 | Ft Lincoln Cemetery   |                                | Colmar Manor Pro Geo  |       | Md.                                     |      |  |
| 24. FUNERAL DIRECTOR   |         |  |                                 | ADDRESS   |                                | 25a. REC'D BY REGISTRAR   |       | 25b. REGISTRAR'S SIGNATURE              |      |  |
| F. Gasch's Sons  |         |  |                                 | Hyattsville, Md.  |                                | OCT 14 1968   |       | J Charles Judge                         |      |  |

25021

1997



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <span>14967</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH<br/>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>14977</span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>                                     |  |  |   |  |  |   |  |  |  |  |  |  |  |  |                           |  |
|---|--|--|---|--|--|---|--|--|--|--|--|--|--|--|---------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><b>William</b>   |  |  | Middle<br><b>Henry</b>  |  |  | Last<br><b>Thomas</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>October</b> Day <b>28</b> Year <b>1968</b> |  |  | 2b. HOUR<br><b>6:35</b> M |  |
| 3. SEX<br><b>Male</b>   |  |  | 4. RACE<br><b>Negro</b>   |  |  | 5. DATE OF BIRTH<br><b>11-6-72</b>  |  |  | 6. AGE (In years last birthday)<br><b>95</b> YRS.                                    |  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                           |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>                                       |                           |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Prince Georges</b> Md.                                      |  |  |  |  |  |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Riverdale</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Eugene Leland Memorial Hosp.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Post Office Worker</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |                           |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Pringe Georges Brentwood</b>  |  |  | 13c. CITY OR TOWN<br><b>3911 Wallace Rd.</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER   |  |  |                           |  |
| 14. FATHER'S NAME<br>First <b>Harry</b> Middle <b>Thomas</b> Last <b>Thomas</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Hannah</b> Middle <b>Barns</b> Last <b></b>                                    |  |  |   |  |  |  |  |  |  |  |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT<br><b>Medical Record</b> Address <b></b>  |  |  |  |  |  |  |  |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4409</b> IMMEDIATE CAUSE (a) <b>uremia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>General arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>undetermined</b> |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4500</b>  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |                           |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |  |  |  |  |                           |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>Hour A.M. <b></b> Month <b></b> Day <b>19</b> Year <b></b><br>P.M. <b></b>                   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |                           |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |  |  | 21f. LOCATION<br>Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>   |  |  |  |  |  |  |  |  |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 11, 1968</b> to <b>Oct 28, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 28, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |  |   |  |  |   |  |  |  |  |  |  |  |  |                           |  |
| 22b. SIGNATURE<br><b>L W Malin MD</b> DEGREE <b></b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |   |  |  |   |  |  |  |  |  |  |  | 22c. DATE SIGNED<br><b>10-28-68</b>  |                           |  |
| 22d. PHYSICIAN'S NAME (Type) <b>L. W. Malin, M. D.</b>  |  |  |   |  |  | 22e. ADDRESS<br><b>4400 Queensbury Road, Riverdale, Md. 20840</b>   |  |  |  |  |  |  |  |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>11-1-68</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Shiloh Methodist Ch. Cemetery</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Newburg, Maryland</b>            |  |  |  |  |  |                           |  |
| 24. FUNERAL DIRECTOR<br><b>John T. Rhines Company Funeral Home</b><br><b>3015 12th Street, N. E.</b>  |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>NOV 1 1968</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>f Charles Judge</b>                                 |  |  |  |  |  |                           |  |

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RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |  |  |   |  |  |  |
| 14968  |  |   |  |  | 14978  |   |  |  |  |
| 1. DECEASED-NAME (Type or print) <b>ANTHONY</b> <b>WAYNE</b> <b>Middle</b> <b>Thompson</b>   |  |   |  |  | 2a. DATE OF DEATH <b>Oct.</b> <b>Month</b> <b>16,</b> <b>Day</b> <b>1968</b> <b>Year</b> |   |  | 2b. HOUR <b>3:30PM</b>   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Caucasian</b>  |  | 5. DATE OF BIRTH <b>Sept. 22, 1968</b>   |  | 6. AGE (In years last birthday) <b>YRS.</b> <b>24</b>   |  | IF UNDER 1 YEAR <b>MONTHS</b> <b>DAYS</b> <b>HOURS</b> <b>MIN.</b> |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Prince George's</b> <b>Md.</b>  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Cheverly</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Infant</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Prince George's</b>  |  | 13c. CITY OR TOWN <b>Suitland</b>  |  | 13d. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  | 13e. STREET AND NUMBER <b>3241 Terrace Drive</b>                   |  |
| 14. FATHER'S NAME <b>Sidney</b> <b>Thompson</b> <b>First</b> <b>Middle</b> <b>Last</b>   |  | 15. MOTHER'S MAIDEN NAME <b>Nancy</b> <b>Lee</b> <b>Norwood</b> <b>First</b> <b>Middle</b> <b>Last</b>  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>Yes</b> <input checked="" type="checkbox"/> <b>No</b> <input type="checkbox"/> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO. <b>NONE</b>  |  | 17. INFORMANT <b>Sidney C. Thompson, Same as #13 (Father)</b> <b>Address</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>7511</b> <b>Peritonitis due to spontaneous perforation of-</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>a recurrence of intestinal obstruction.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>7562</b> <b>Congenital Atresia of Ileum.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congenital Gastroschisis.</b> |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY <b>Hour</b> <b>A.M.</b> <b>Month</b> <b>Day</b> <b>Year</b> <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |  |
| 21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION <b>Street or R.F.D. No.</b> <b>City or Town</b> <b>County</b> <b>State</b>   |  |   |  |  |  |
| 22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>Sept. 22, 1968</b> , to <b>Oct. 16, 1968</b> , that (I) <del>(xxx)</del> last saw the deceased alive on <b>Oct. 16, 1968</b> , and that in (my) <del>(xxx)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(xxx)</del> (did) <del>(xxx)</del> view the body after death.  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE <b>R. Longoria M.D.</b>   |  | DEGREE <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Ricardo Longoria M.D.</b>  |  | 22e. ADDRESS <b>6001 Landover Road, Cheverly, Md.</b>   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 23b. DATE <b>10-18-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION (City or Town) <b>Suitland, Maryland</b> (County) (State)                         |  |  |  |
| 24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b> ADDRESS <b>4308 Suitland Rd. Suitland, Maryland</b>   |  |   |  | 25a. REC'D BY REGISTRAR <b>Oct 23 1968</b> DATE  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |  |  |

1984, 22, 1002

1990-1991

Prince of Wales Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                      |  |  |          |   |      |   |   |  |                                |                   |  |
|--|--|----------------------|--|--|----------|---|------|---|---|--|--------------------------------|-------------------|--|
| 14969  |  | CERTIFICATE OF DEATH |  |  |          |   |      | 14979   |   |  |                                |                   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |                      | First  |  | Middle   |   | Lost |   | 2a. DATE OF DEATH   |  | 2b. HOUR A M                   |                   |  |
| Ruth   |  |                      | T.   |  | Traicoff |   |      |   | Oct. Month 25, Day 1968   |  | 10:30                          |                   |  |
| 3. SEX   |  |                      | 4. RACE  |  |          | 5. DATE OF BIRTH  |      |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS |                   |  |
| Female   |  |                      | Caucasian  |  |          | Oct. 1, 1912  |      |   | 56 YRS.   |  | IF UNDER 24 HRS.<br>HOURS MIN  |                   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |                      | 7b. CITIZEN OF WHAT COUNTRY?   |  |          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |   | 9. COUNTY OF DEATH  |  |                                | Md.               |  |
| Kentucky   |  |                      | U.S.A.   |  |          |   |      |   | Prince George's   |  |                                |                   |  |
| 10. CITY OR TOWN OF DEATH  |  |                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |      |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                | HOME              |  |
| Cheverly   |  |                      | Prince Geo.Gen'l Hospital  |  |          | Housewife   |      |   |   |  |                                |                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                      | 13b. COUNTY  |  |          | 13c. CITY OR TOWN   |      |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER         |                   |  |
| Maryland   |  |                      | Prince George's  |  |          | Dist.Hgts.  |      |   | YES   |  | 7903 Foster St.                |                   |  |
| 14. FATHER'S NAME  |  |                      | First  |  | Middle   |   | Lost |   | 15. MOTHER'S MAIDEN NAME  |  |                                | First Middle Last |  |
| David  |  |                      | Winsted  |  |          |   |      |   | Mabel   |  |                                | Riley             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  |                      | 16b. SOCIAL SECURITY NO.   |  |          | 17. INFORMANT   |      |   | Address   |  |                                |                   |  |
| NO   |  |                      | UNKNOWN  |  |          | Dimitri Traicoff - same as above  |      |   |   |  |                                |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC AND RESPIRATORY ARREST.</u><br><u>174X</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastatic carcinoma to lungs and pericardium</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Carcinoma Right breast - (Radical mastectomy 8 yrs ago)</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                      |  |  |          |   |      |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |                                |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>170X</u>  |  |                      |  |  |          |   |      |   |   |  |                                |                   |  |
| 19a. DATE OF OPERATION   |  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |          | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |      |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>Yes                     |  |                                |                   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |                      | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |      |   |   |  |                                |                   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |                      | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |      |   |   |  |                                |                   |  |
| 22a. I certify that (this hospital) attended the deceased from <u>Oct. 18, 1968</u> , to <u>Oct. 25, 1968</u> , that <u>xx</u> (we) last saw the deceased alive on <u>Oct. 25, 1968</u> , and that in <u>xx</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>xx</u> (we) (did) <u>xx</u> view the body after death.  |  |                      |  |  |          |   |      |   |   |  |                                |                   |  |
| 22b. SIGNATURE<br><u>Luis F. Bentolila</u>   |  |                      |  |  |          |   |      | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><u>10-25-68.</u>               |                                |                   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Luis F. Bentolila, M. D.</u>  |  |                      |  |  |          |   |      | 22e. ADDRESS<br><u>Prince Geo.Gen'l Hospital, Cheverly, Md.</u>   |   |  |                                |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Type)   |  |                      | 23b. DATE  |  |          | 23c. NAME OF CEMETERY OR CREMATORY  |      |   | 23d. LOCATION (City or Town) (County) (State)   |  |                                |                   |  |
| Burial   |  |                      | 10-28-68   |  |          | CEDAR HILL CEMETERY   |      |   | SUITLAND, MARYLAND  |  |                                |                   |  |
| 24. FUNERAL DIRECTOR <u>Wilhelm Funeral Home</u> ADDRESS<br><u>4308 Suitland Rd., Suitland, Maryland</u>   |  |                      |  |  |          |   |      | 25a. REC'D BY REGISTRAR<br>DATE <u>NOV 1 1968</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |                                |                   |  |

John R. Schuchman, Esq.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14970

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #7a, b Film GL 001176

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14980

|  |                         |   |   |   |  |
|--|-------------------------|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or Print)<br>First: <b>Bernard</b> Middle: <b>G</b> Last: <b>Tydings</b>   |                         |   | 2a. DATE KNOWN OF DEATH<br>Month: <b>10</b> Day: <b>9</b> Year: <b>68</b> 19 <b>4:30pm</b> AM |   | 2b. HOUR                                     |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>7-30-1915</b>  | 6. AGE (in years last birthday)<br><b>53</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS:    DAYS:    HOURS:    MIN.   | IF UNDER 24 HRS.                             |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bladensburg</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>5350 Quincy Place</b>      |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired).<br><b>Trainman</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Prince George's</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Washington Terminal</b>   |  |
| 13c. CITY OR TOWN<br><b>Bladensburg</b>  |                         | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>5350 Quincy Place</b>  |  |
| 14. FATHER'S NAME<br>First: <b>Clement</b> Middle: <b>Tydings</b> Last: <b></b>  |                         |   | 15. MOTHER'S MAIDEN NAME<br>First: <b>Florence</b> Middle: <b>Butler</b> Last: <b></b>        |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>no</b>   |                         | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)   |   | 17. INFORMANT<br><b>Mrs Marian E Tydings</b>  |  |
|  |                         |   |   | ADDRESS<br><b>Bladensburg, Md.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>955X</b> IMMEDIATE CAUSE (a) <b>Gun shot wound of head</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |                         |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>976X</b>   |                         |   |   |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                         | 21b. TIME OF INJURY Month, Day, Year<br><b>11:00am 10-9-1968</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Shot self at home</b>   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Home</b>                   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>Same as #13</b>  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |   |   |   |  |
| ACTUAL SIGNATURE<br><b>John Kehoe MD</b>   |                         | M.D.<br><b>Riverdale, Md.</b>   |   | 22b. DATE SIGNED<br><b>10-10-68</b>   |  |
| EXAMINER'S NAME (Type)<br><b>John Kehoe MD</b>   |                         | 23a. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln Cemetery</b>  |   | 23b. LOCATION (City or Town) (County) (State)<br><b>Colmar Manor, Pro Geo Md.</b>   |  |
| 23c. DATE<br><b>Oct 12, 1968</b>   |                         | 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b>  |   | 25a. REC'D BY REGISTRAR<br><b>OCT 14 1968</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                         |   |   |   |  |

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

|  |  |  |        |  |                   |  |          |  |  |                             |  |
|--|--|--|--------|--|-------------------|--|----------|--|--|-----------------------------|--|
| 1. DECEASED-NAME (Type or print)   |  | First  | Middle | Last   | 2a. DATE OF DEATH |  | 2b. HOUR |  |  |                             |  |
| <del>HAZEL I.</del> Hazel I. TYLER   |  |  |        |  | 10- Month Day 68  |  | 4:15 PM  |  |  |                             |  |
| 3. SEX   |  | 4. RACE  |        | 5. DATE OF BIRTH   |                   | 6. AGE (In years last birthday)  |          | IF UNDER 1 YEAR MONTHS DAYS                  |  | IF UNDER 24 HRS. HOURS MIN. |  |
| Female   |  | White  |        | 7-1-98   |                   | 70 YRS.  |          |  |  |                             |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                   | 9. COUNTY OF DEATH   |          |  |  |                             |  |
| Md.  |  | US   |        |  |                   | Prince Georges Md.   |          |  |  |                             |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |                   | 12b. KIND OF BUSINESS OR INDUSTRY  |          |  |  |                             |  |
| Riverdale, Md.   |  | Leland Memorial Hosp.  |        | HOUSEWIFE  |                   | HOME   |          |  |  |                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |        | 13c. CITY OR TOWN  |                   | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          | 13e. STREET AND NUMBER                       |  |                             |  |
| Md.  |  | Howard   |        | Laurel   |                   |  |          | Rt #5  |  |                             |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)   |                   | 16b. SOCIAL SECURITY NO.   |          | 17. INFORMANT                                |  | Address                     |  |
| WILLIE William W   |  | Helen Wills  |        | no   |                   |  |          | EDNA PUNCKE LAUREL MD                        |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)                                |  | DUE TO, OR AS A CONSEQUENCE OF   |        | DUE TO, OR AS A CONSEQUENCE OF   |                   | DUE TO, OR AS A CONSEQUENCE OF   |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                             |  |
| 4109   |  |  |        |  |                   |  |          |  |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                       |  |  |        |  |                   |  |          |  |  |                             |  |
| 4201   |  |  |        |  |                   |  |          |  |  |                             |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                     |          |  |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)       |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                   |  |          |  |  |                             |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                   |  |          |  |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1968, 1968, that (I) (we) lost  |  | 22b. SIGNATURE   |        | 22c. DATE SIGNED   |                   |  |          |  |  |                             |  |
| 22d. PHYSICIAN'S NAME (Type) ROBERT C. WINGFIELD   |  | 22e. ADDRESS Laurel, Maryland  |        | 22f. DATE  |                   | OCT 28 1968  |          | 22g. REGISTRAR'S SIGNATURE                   |  | Charles Judge               |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY   |                   | 23d. LOCATION (City or Town) (County) (State)  |          |  |  |                             |  |
| Burial   |  | 10-26-68   |        | PLEASANT HILL  |                   | YELLOW SPRINGS MD  |          |  |  |                             |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |        | 25a. REC'D BY REGISTRAR  |                   | 25b. REGISTRAR'S SIGNATURE   |          |  |  |                             |  |
| Donaldson Funeral Home, Laurel   |  |  |        | DATE   |                   | OCT 28 1968  |          |  |  |                             |  |

18841

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

18841

18841

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |                                       |   |  |  |  |   |  |                                |  |
|---|--|--|--|---|---------------------------------------|---|--|--|--|---|--|--------------------------------|--|
| 14972   |  |  |  |   |                                       | 14982   |  |  |  |   |  |                                |  |
| 1. DECEASED-NAME<br>(Type or print)<br><b>Annie Wade</b>  |  |  |  | First Middle Last   |                                       |   |  | 2a. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>13</b> Year <b>68</b>  |  |   |  | 2b. HOUR<br><b>12,55A</b>      |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>14 Nov., 1904</b>  |                                       |   |  | 6. AGE (In years last birthday)<br><b>63</b> YRS.                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>England</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. COUNTY OF DEATH<br><b>Pr. Geo., Md.</b>  |  |  |  |   |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Pr. Geo., Gen. Hosp.,</b> |   |                                       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b> |   |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Pr., Geo.,</b>   |   | 13c. CITY OR TOWN<br><b>Greenbelt</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>15 B Ridge Rd.</b>      |   |  |                                |  |
| 14. FATHER'S NAME<br>First <b>Andrew</b> Middle <b>Hinchliffe</b> Last <b>Any</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Any</b> Middle <b>Rhodes</b> Last <b>Rhodes</b>  |                                       |   |  |  |  |   |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>119 26 3976</b>  |                                       | 17. INFORMANT<br><b>Willie Wade</b>   |  |  | Address<br><b>Same as 13</b>                         |   |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Metastatic leukemia</b><br><b>174X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Adeno carcinoma of rt breast</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1 year</b> |  |  |  |   |                                       |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>170X</b>   |  |  |  |   |                                       |   |  |  |  |   |  |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                       |   |  |  |  |   |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                       |   |  |  |  |   |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 1967, to <b>Oct 13</b> , 1968, that (I) (we) last saw the deceased alive on <b>Oct 13</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |                                       |   |  |  |  |   |  |                                |  |
| 22b. SIGNATURE<br><b>William C. Weintraub, MD</b>   |  |  |  |   |                                       |   |  | 22c. DATE SIGNED   |  |   |  |                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William C. Weintraub</b>   |  | 22e. ADDRESS<br><b>Greenbelt ProfslBg Greenbelt Md.</b>                      |  |   |                                       |   |  |  |  |   |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>10/16/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |                                       | 23d. LOCATION (City or Town) (County) (State)<br><b>Colmar Manor Pro. Geo. Md.</b>                          |  |  |  |   |  |                                |  |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons Hyattsville, Maryland</b>  |  |  |  | ADDRESS   |                                       | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 16 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |  |   |  |                                |  |

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CERTIFICATE OF DEATH

14983

|   |  |  |   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>James</b>   |  |  | First Middle Last<br><b>-- Waiters</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>10</b> Day <b>27</b> Year <b>68</b>   |  |  | 2b. HOUR<br><b>5:50</b> <sup>A</sup> M   |  |  |
| 3. SEX<br><b>Male</b>   |  |  | 4. RACE<br><b>Negro</b>   |  |  | 5. DATE OF BIRTH<br><b>1/22/1923</b>  |  |  | 6. AGE (In years -<br>last birthday)<br><b>45</b> YRS.                             |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>S. C.</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Prince Georges</b> Md.                                    |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Glenn Dale</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Glenn Dale Hospital</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>unknown</b>  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>unknown</b>                             |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>MD</b>   |  |  | 13b. COUNTY<br><b>Wash., D.C.</b>   |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 13e. STREET AND NUMBER<br><b>644 Columbia Rd., N. W.</b>                           |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Unknown</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Unknown</b>   |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>unknown</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>unknown</b>  |  |  | 17. INFORMANT<br>Address<br><b>D.C. General Hospital Records</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma, left lung, with metasta-</b><br><b>sis (autopsy finding)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. <b>1621</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>unknown</b> |  |  |   |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <b>Left cerebral in-</b><br><b>farction, old, with right hemiplegia and aphasia; generalized arteriosclerosis</b>   |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? <b>Yes</b> |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                               |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that <del>xx</del> (this hospital) attended the deceased from <b>3/20/</b> 19 <b>68</b> , to <b>10/27/</b> 19 <b>68</b> , that <del>xx</del> (we) last<br>saw the deceased alive on <b>10/27/</b> 19 <b>68</b> , and that in <del>xxx</del> (our) opinion death occurred on the date and hour and from the<br>causes stated above, <del>xxx</del> (we) (did) <del>not</del> view the body after death.   |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Moe Weiss</b>  |  |  |   |  |  | DEGREE ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input checked="" type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>             |  |  | 22c. DATE SIGNED<br><b>10/27/68</b>  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>Moe Weiss, M. D.</b>  |  |  |   |  |  | 22e. ADDRESS<br><b>Glenn Dale Hospital<br/>Glenn Dale, Maryland</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>11/4/68</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harmony Memorial Park</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Maryland</b>                   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Stewart Funeral Home</b>   |  |  |   |  |  | ADDRESS<br><b>4001 Benning Rd.</b>  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>NOV 4 1968</b>                                  |  |  |
|   |  |  |   |  |  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                 |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Glenn Dale Hospital  
Glenn Dale, Maryland  
644 Columbia Rd., N.W.  
Washington, D.C.

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U.S. General Hospital Records  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14974

14984

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>PRINCE GEORGES</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>VIRGINIA</b> b. COUNTY <b>Fairfax</b>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ANDREWS AFB</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fairfax 22030</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MALCOM GROW USAF HOSP</b>  |   | d. STREET ADDRESS<br><b>9126 Glenbrook Road</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>SARAH</b> Middle <b>J</b> Last <b>WEST</b>  |   | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>20</b> Year <b>1968</b>  |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>CAU</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>27 Nov 1911</b>  |
| 9. AGE (In years last birthday) yrs.<br><b>56</b>   |   | 10. IF UNDER 1 YEAR Months Days Hours Min.<br>IF UNDER 24 HRS.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Business Manager</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Pennsylvania</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Samuel K. Webster</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Ethel <del>Webster</del> Marie Hood</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>089-05-1554</b>   |   |
| 17. INFORMANT<br><b>Frank T West</b>  |   | Address<br><b>9126 Glenbrook Rd, Fairfax, Va.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b><br><b>1991</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) DUE TO<br>(c) DUE TO |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>1992</b>   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (this hospital) attended the deceased from <b>22 July 1968</b> to <b>20 Oct 1968</b> that (I) (we) last saw the deceased alive on <b>20 Oct. 1968</b> and that death occurred at <b>00K AM</b> from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><b>G. O. HATZIMIHALIS</b>   |   | 22b. DATE SIGNED<br><b>20 Oct 68</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>G. O. HATZIMIHALIS, M.D.</b>   |   | 22d. ADDRESS<br><b>MALCOM GROW USAF HOSP. ANDREWS AFB, WASH D.C.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>10/23/68</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cem., Arlington, Virginia</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Falls Church, Falls Church, Va.</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 22 1968</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>f Charles Judge</b>  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 14975   |  |  |  |   |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |                         |  |  |  | 14985 |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Mary Elizabeth R. Wilding   |  |  |  |   |  |  |  |  |  |  |  | 2a. DATE OF DEATH Month Day Year<br>October 29 1968   |  |  |  |   |  |  |  | 2b. HOUR P M<br>5:50 PM |  |  |  |       |  |  |  |
| 3. SEX<br>Female  |  |  |  | 4. RACE<br>White  |  |  |  | 5. DATE OF BIRTH<br>May 8, 1889  |  |  |  | 6. AGE (In years last birthday)<br>79 YRS.  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN |  |  |  |                         |  |  |  |       |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>District of Columbia   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH<br>Prince George Md  |  |  |  |   |  |  |  |                         |  |  |  |       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Hyattsville  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Sacred Heart Home |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Clerical  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Government U.S.  |  |  |  |   |  |  |  |                         |  |  |  |       |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Prince George  |  |  |  | 13c. CITY OR TOWN<br>Hyattsville   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  |  |  | 13e. STREET AND NUMBER<br>620 Sheridan St. Apt. 319       |  |  |  |                         |  |  |  |       |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>William A. Wilding   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Mary Frances O'Dea                                  |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |                         |  |  |  |       |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no   |  |  |  | 16b. SOCIAL SECURITY NO.<br>579-60-5108   |  |  |  | 17. INFORMANT<br>Margaret Sellers, 620 Sheridan Street, Hyattsville, Maryland  |  |  |  |   |  |  |  |   |  |  |  |                         |  |  |  |       |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral thrombosis<br>4129<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200<br>(b) Arteriosclerotic heart disease with<br>DUE TO, OR AS A CONSEQUENCE OF<br>auricular fibrillation<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 wks.<br>undet. |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |                         |  |  |  |       |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Parkinsonism, severe.  |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |                         |  |  |  |       |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |   |  |  |  |                         |  |  |  |       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |  |  |  |   |  |  |  |                         |  |  |  |       |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                      |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |  |  |  |   |  |  |  |                         |  |  |  |       |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 1952, to Oct 29 1968, that (I) (we) last saw the deceased alive on Oct 29 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |                         |  |  |  |       |  |  |  |
| 22b. SIGNATURE<br>[Signature] MD DEGREE   |  |  |  |   |  |  |  |  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br>Oct 29, 1968                          |  |  |  |                         |  |  |  |       |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) William F. Simpson, MD   |  |  |  |   |  |  |  |  |  |  |  | 22e. ADDRESS<br>6216 NH Ave NE - DC 20011   |  |  |  |   |  |  |  |                         |  |  |  |       |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  |  | 23b. DATE<br>11-2-1968  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet Cemetery  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Washington, D. C.  |  |  |  |   |  |  |  |                         |  |  |  |       |  |  |  |
| 24. FUNERAL DIRECTOR<br>John W. Lee<br>Barrett E. Pumphrey, Inc. 8434 Ga. Avenue  |  |  |  |   |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>NOV 7 1968   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                 |  |  |  |                         |  |  |  |       |  |  |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1. 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14976

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14986

|   |                  |                                       |  |   |                  |  |  |  |  |
|---|------------------|---------------------------------------|--|---|------------------|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)<br>First Middle Last<br>David P Wilkins   |                  |                                       | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED<br>10-31-68 11:12pm  |   |                  | 2b. HOUR   |  |  |  |
| 3. SEX<br>Male  | 4. RACE<br>White | 5. DATE OF BIRTH<br>2-4-1954          | 6. AGE (in years<br>last birthday)<br>14 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>10 31 68 11:30am   |  |  | 2d. HOUR   |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Mass.   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. COUNTY OF DEATH<br>Prince George's Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Clinton  |                  |                                       | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital<br>give street address)<br>Clinton Medical Center  |   |                  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Student                      |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland  |                  |                                       | 13b. COUNTY<br>Prince George's Cheltenham  |   |                  | 13c. CITY OR TOWN<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                   |  |  | 13d. STREET AND NUMBER<br>Quarters B                                   |
| 14. FATHER'S NAME<br>First Middle Last<br>William R. Wilkins  |                  |                                       | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Fern E. Stahl   |   |                  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No   |                  |                                       | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>- - -   |   |                  | 17. INFORMANT<br>ADDRESS<br>William R. Wilkins Quarters B.<br>Naval Com. Sta.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Laceration of brain<br>8121<br>DUE TO, OR AS A CONSEQUENCE OF Trauma auto accident<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>lost.<br>(c)   |                  |                                       |  |   |                  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>8164   |                  |                                       |  |   |                  |  |  |  |  |
| 19a. DATE OF OPERATION  |                  |                                       | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?   |   |                  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                  |                                       | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>11:00am 10-31-19 68   |   |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Passenger of car involved in collision. |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |                  |                                       | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)<br>Rt. 5, 200 feet north of Rt. 381, T.B., Prince George Co., Md.  |   |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |                                       |  |   |                  |  |  |  |  |
| ACTUAL<br>SIGNATURE<br>EXAMINER'S<br>NAME (Type)<br>John Kehoe MD Riverdale, Md.  |                  |                                       | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town, or county) |   |                  | 22b. DATE SIGNED<br>11-1-68  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Cremation   |                  |                                       | 23b. DATE<br>11-4-68   |   |                  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Suitland Pr. Geo. Md. |
| 24. FUNERAL DIRECTOR<br>Wilhelm Funeral Home  |                  |                                       | ADDRESS<br>4308 Suitland Rd. S. E.   |   |                  | 25a. REC'D BY REGISTRAR<br>DATE NOV 6 1968   |  |  | 25b. REGISTRAR'S SIGNATURE<br>J Charles Judge                          |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14977

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14987

|   |                         |   |   |   |   |   |  |  |  |
|---|-------------------------|---|---|---|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)<br>First Middle Last<br><b>Frances Louise Wood</b>  |                         |   | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br><b>10-15-68</b>            |   |   | 2b. HOUR<br>Minute<br><b>10:00am</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>2-1-1915</b>   | 6. AGE (In years lost birthday)<br><b>53</b> YRS.                       | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   | IF UNDER 24 HRS<br>HOURS MIN.   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>10 15 68</b>   |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Texas</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hyattsville</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>8303 Fremont Place</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Prince George's</b>   |   | 13c. CITY OR TOWN<br><b>Hyattsville</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>8303 Fremont Place</b>  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Harold Smith</b>   |                         |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Willie V Vaughn</b> |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>no</b>  |                         | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>577 24 5263</b>                   |   | 17. INFORMANT<br><b>Walter H Wood</b>   |   |   | ADDRESS<br><b>Hyattsville, Md.</b>               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxia</b><br>953X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF <b>Hanging</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |                         |   |   |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>974X   |                         |   |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br><b>10:00am 10-15-68</b>                              |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Hung self in basement of home.</b>                                    |   |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Basement of home</b>   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>same as #13</b>  |   |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |   |   |   |   |   |  |  |  |
| ACTUAL SIGNATURE<br><b>John Kehoe</b>   |                         | EXAMINER'S NAME (Type)<br><b>John Kehoe MD</b>  |   | RIVERDALE, Md.  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br><b>10-16-68</b>                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>Oct 18, 1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Colmar Manor, Pro Geo Md.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b>  |                         |   |   | ADDRESS<br><b>Hyattsville, Md.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>OCT 21 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b> |  |

1503

100

100

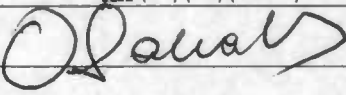
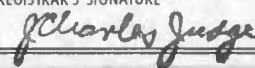
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14978

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14988

|   |           |   |                  |   |                                     |   |                                |   |
|---|-----------|---|------------------|---|-------------------------------------|---|--------------------------------|---|
| 1. DECEASED-NAME<br>(Type or print)   |           | First   | Middle           | Last  | 2a. DATE OF DEATH<br>Month Day Year |   | 2b. HOUR<br>A                  |   |
| Mary  |           | A.  | Woodworth        |   | Oct. 16, 1968                       |   | 10:30                          |   |
| 3. SEX  | 4. RACE   |   | 5. DATE OF BIRTH |   | 6. AGE (In years<br>last birthday)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS |   |
| Female  | Caucasian |   | Jan. 1, 1884     |   | 84 YRS.                             |   | IF UNDER 24 HRS.<br>HOURS MIN. |   |
| 7a. BIRTHPLACE (State or foreign<br>country)  |           | 7b. CITIZEN OF WHAT COUNTRY?<br>give street address)                            |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. COUNTY OF DEATH  |                                |   |
| Ill.  |           | U. S. A.  |                  |   |                                     | Prince George's Md.   |                                |   |
| 10. CITY OR TOWN OF DEATH   |           | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |                  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |                                     | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |                                |   |
| Cheverly  |           | Prince Geo. Gen'l Hospital  |                  | House wife  |                                     | Own Home  |                                |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |           | 13b. COUNTY   |                  | 13c. CITY OR TOWN   |                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                | 13e. STREET AND NUMBER                          |
| Maryland  |           | Prince George's   |                  | Kent Village  |                                     |   |                                | 2818 74th Avenue                                |
| 14. FATHER'S NAME   |           | First   | Middle           | Lost  | 15. MOTHER'S MAIDEN NAME            |   | First                          | Middle  |
| Thomas Voyles   |           |   |                  |   | Ella ??                             |   |                                |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)  |           | 16b. SOCIAL SECURITY NO.  |                  | 17. INFORMANT   |                                     |   |                                |   |
| No  |           | 213 56 8602   |                  | Pauline Fratantuono Same as # 13  |                                     |   |                                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypotension</u><br><u>402x</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) <u>Cerebrovascular accident - Cerebral thrombosis.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Hypertensive Heart Disease.</u>  |           |   |                  |   |                                     |   |                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>443x</u>  |           |   |                  |   |                                     |   |                                |   |
| 19a. DATE OF OPERATION  |           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?               |                                |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |           | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                     |   |                                |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |           | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                     |   |                                |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Oct. 8,</u> 19 <u>68</u> , to <u>Oct. 16,</u> 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last<br>saw the deceased alive on <u>Oct. 16,</u> 19 <u>68</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the<br>causes stated above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |           |   |                  |   |                                     |   |                                |   |
| 22b. SIGNATURE  |           | 22c. DATE SIGNED  |                  | 22d. PHYSICIAN'S<br>NAME (Type)   |                                     |   |                                |   |
|    |           | Oct. 16, 1968   |                  | Ohannes Sahakyan, M. D.   |                                     |   |                                |   |
| 22e. ADDRESS  |           | 22f. ADDRESS  |                  |   |                                     |   |                                |   |
| Prince Geo. Gen'l Hospital, Cheverly, Md.   |           | Prince Geo. Gen'l Hospital, Cheverly, Md.                                       |                  |   |                                     |   |                                |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |           | 23b. DATE   |                  | 23c. NAME OF CEMETERY OR CREMATORY  |                                     | 23d. LOCATION (City or Town) (County) (State)   |                                |   |
| Burial  |           | 10/19/68  |                  | Bethel Cemetery   |                                     | Dahlgren Ill  |                                |   |
| 24. FUNERAL DIRECTOR  |           | ADDRESS   |                  | 25a. REC'D BY REGISTRAR   |                                     | 25b. REGISTRAR'S SIGNATURE  |                                |   |
| France's Gasch's Sons   |           | Hyattsville, Md.  |                  | DATE OCT 21 1968  |                                     |  |                                |   |

2521



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |   |   |                                  |  |
|--|--|--|--|--|---|---|---|----------------------------------|--|
| <div style="display: flex; justify-content: space-between;"> <span>14979</span> <span>CERTIFICATE OF DEATH</span> <span>16473</span> </div>  |  |  |  |  |   |   |   |                                  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |   | 2a. DATE OF DEATH   |   |                                  | 2b. HOUR                                     |
| Baby Girl  |  |  | Yasler   |  |   | Month Day Year<br>Oct., 22 1968   |   |                                  | 11.59 P                                      |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   |   | 6. AGE (In years lost birthday)   |                                  | IF UNDER 1 YEAR MONTHS DAYS                  |
| Female   |  | White  |  | 22 Oct., 1968  |   |   | YRS.  |                                  | IF UNDER 24 HRS. HOURS MIN.                  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   |                                  |  |
| Maryland   |  |  |  |  |   | Pr. Geo., Md.   |   |                                  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   |                                  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Cheverly   |  |  | Pr. Geo. Gen., Hosp.,  |  |   |   |   |                                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                  | 13e. STREET AND NUMBER                       |
| Maryland   |  |  | Pr. Geo.,  |  | Bowie   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |                                  | 12345 Melling Lane                           |
| 14. FATHER'S NAME First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |   |   |   |                                  |  |
| Scott Yasler   |  |  | Margaret Mullany   |  |   |   |   |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |   | Address   |                                  |  |
|  |  |  |  |  |   |   |   |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |   |   |   |                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |   |   |   |                                  |  |
| IMMEDIATE CAUSE (a) <u>Atalectasis Neonatorum</u>  |  |  |  |  |   |   |   |                                  | 59 min.                                      |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |   |   |                                  |  |
| (b) <u>Prematurity</u>   |  |  |  |  |   |   |   |                                  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |   |   |                                  |  |
| (c)  |  |  |  |  |   |   |   |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |   |   |   |                                  |  |
| 7625   |  |  |  |  |   |   |   |                                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |                                  |  |
|  |  |  |  |  |   |   |   |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |   |                                  |  |
|  |  |  |  |  |   |   |   |                                  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |   | City or Town  |   | County                           | State  |
|  |  |  |  |  |   |   |   |                                  |  |
| 22a. I certify that (he) (this hospital) attended the deceased from <u>Oct. 22</u> , 19 <u>68</u> , to <u>Oct. 22</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct. 22</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |   |   |                                  |  |
| 22b. SIGNATURE <u>John H. Moling, M.D.</u>   |  |  |  | DEGREE   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED <u>10-23-68</u> |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  | 22e. ADDRESS   |   |   |   |                                  |  |
| John H. Moling, M. D.  |  |  |  | 12107 Linden Lane, Bowie, Md. 20715  |   |   |   |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   |   | 23d. LOCATION (City or Town) (County) (State)                                     |                                  |  |
|  |  | 11/23/68   |  | Prince Geo. General Hosp.  |   |   | Cheverly, Maryland  |                                  |  |
| 24. FUNERAL DIRECTOR <u>HARRY W. DENNY, JR., ADMINISTRATOR</u>   |  |  |  | ADDRESS  |   | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE       |  |
|  |  |  |  |  |   | DATE <u>NOV 29 1968</u>   |   | <u>Charles Judge</u>             |  |

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